

Job Satisfaction and Health Experience of People With a Lower-Limb Amputation in Comparison With Healthy Colleagues

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ABSTRACT. Schoppen T, Boonstra A, Groothoff JW, de Vries J, Göeken LN, Eisma WH. Job satisfaction and health experience of people with a lower-limb amputation in comparison with healthy colleagues. *Arch Phys Med Rehabil* 2002;83:628-34.

Objectives: To describe indicators of job dissatisfaction among amputee employees and to compare job satisfaction and health experience of working amputee employees with that of control subjects.

Design: A cross-sectional study, mailed questionnaire.

Setting: Patients were recruited by the orthopedic workshops of the Netherlands.

Participants: One hundred forty-four patients who had an acquired unilateral major amputation of the lower limb at least 2 years before, were aged 18 to 60 years (mean age, 43y), and were living and working in the Netherlands. One hundred forty-four control subjects matched for age, gender, and type of job.

Interventions: Not applicable.

Main Outcome Measures: Statistical analysis of responses to a questionnaire regarding patient characteristics and amputation-related factors, amputee patients' opinions about their work and the social atmosphere at work, and their general health (RAND 36-Item Health Survey [RAND-36]).

Results: People with an amputation had greater job satisfaction (70%) than did the able-bodied control group (54%). The wish for (better) modifications in the workplace and the presence of comorbidity were significantly related to job dissatisfaction in people with limb loss. Amputee employees were less often hindered by the failures of others and by fluctuations in temperature. People with limb loss showed a worse physical health experience than controls on the RAND-36.

Conclusions: The vocational satisfaction of people with limb loss may be improved by better workplace modifications, depending on the functional capabilities of the person and the functional demands of the job; improvement may also be achieved by vocational rehabilitation programs, especially for those with an amputation in combination with other morbidity. Despite experiencing more health problems, the amputee group

expressed greater job satisfaction than the able-bodied group, reflecting a great appreciation of job reintegration by people with a lower-limb amputation.

Key Words: Amputation; Job satisfaction; Leg; Rehabilitation.

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IN PREVIOUS RESEARCH,¹ we showed a relatively high job participation—ie, comparable with the general Dutch population—of amputee patients in the Netherlands. However, people with a lower-limb amputation who were 40 years or older showed a decline in job participation. In general, job participation is important, but job satisfaction plays a role as well. In research of patients with several chronic diseases, many problems have been described that relate to insurance, reintegration after illness, fewer possibilities for promotion, more hindrances at the workplace, conflicts with colleagues, and threats of dismissal.²⁻⁷ Nevertheless, chronically disabled people emphasized the relevance of job reintegration for their self-respect. Despite the aforementioned problems and more physical restrictions in the workplace, people with a chronic disease or handicap tended to judge their work more favorably than healthy people.^{3,5,7} Job reintegration even positively influenced the health perception of these subjects.^{8,9}

In people between the ages of 18 and 60 years with a unilateral above-knee amputation because of war injury or accidents, Gerhards et al¹⁰ reported that amputee employees rated their job satisfaction higher than their controls despite the amputee employees' lower occupational status. Subjects who reported higher contentment with their current occupational status had enjoyed better social integration after the amputation. They described themselves as being rather extroverted and daring, and they had a higher educational level than subjects who were less content. In other literature on people with an amputation, less attention has been paid to job reintegration, vocational satisfaction, and problems at the workplace.

The first purpose of the present study was to describe demographic and amputation-related indicators of job dissatisfaction among amputee patients. The second purpose was to compare the job satisfaction and health experience of working people with limb loss in comparison with matched control subjects of the same gender, age, and kind of job. The present study is part of a larger study on the employment status of amputee patients in the Netherlands. Other data have been presented elsewhere.¹

METHODS

Participants

Participants with a lower-limb amputation. Persons who had an acquired unilateral major amputation of the lower limb, between the ages of 18 and 60 years at the time of the

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Accepted in revised form May 16, 2001.

Supported by the Dutch Health Science Promotion Program.

No commercial party having a direct financial interest in the results of the research supporting this article has or will confer a benefit upon the author(s) or upon any organization with which the author(s) is/are associated.

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0003-9993/02/8305-6708\$35.00/0

doi:10.1053/apmr.2002.32473

study, and were living in the Netherlands were included in the study. To create a stable situation for which the employment status could best be judged, time since amputation was at least 2 years. All patients were working at the time of the study. Patients with severe cognitive problems or difficulties with the Dutch language who could not fill out a questionnaire were excluded. The study was approved by the Medical Ethical Committee of the University Hospital Groningen.

We asked 49 orthopedic workshops (almost all existing workshops) in the Netherlands to participate in the recruitment of patients for the study. Twenty-five orthopedic workshops had no or very few amputee patients in their files who met the inclusion criteria. These workshops dealt only with orthotics and not with prosthetics. Of the other 24 workshops, 13 could not participate for a variety of reasons. It is likely that some of these workshops also did not have subjects in their files who met the inclusion criteria. Finally, 11 orthopedic workshops in the Netherlands with amputee patients between the ages of 18 and 60 years sent their patients a letter in which they asked consent to give the patients' name and address to the Department of Rehabilitation of the University Hospital Groningen. Patients were asked to return a signed consent slip. Of the total number of patients asked to participate by the orthopedic workshops, approximately 55% returned the signed consent slips. Researchers telephoned the patients to check the inclusion and exclusion criteria and to ask about their employment status. After the telephone calls, a questionnaire was sent to the patients. Of the 687 patients who received a questionnaire, 652 returned it, which is a response rate of 95%. In the present part of the study, we included only 413 respondents who were working at the time of the study. We asked respondents to recommend an able-bodied colleague who also would like to participate in the study. One hundred fifty-one subjects recommended a coworker as control subject. One hundred forty-four coworkers returned the questionnaire. So, in the present study, the data of 144 amputee subjects and 144 control subjects were used.

Control subjects. We asked all patients to search for a colleague within the company who was doing the same kind of job, was of the same gender, and was about the same age. Precise instructions were sent along with the questionnaire. Participants with an amputation first informed their colleagues and requested consent to give their name and address to the researchers. Subsequently, a questionnaire was sent to the control subjects.

Questionnaires

The participants with an amputation received 2 questionnaires. The first questionnaire consisted of 2 sections. In the first section, the questions concerned patient characteristics and aspects related to the amputation such as side, level, reason, pain, use, and wearing comfort of prosthesis, walking distance, and comorbidity. The second section consisted of a questionnaire developed by the TNO (Netherlands Organization for Applied Scientific Research) Vocational Handicap Research Program.^{7,11-13} In this questionnaire, job characteristics are explored, and vocational handicaps are assessed by comparing job demands and amputee employee and co-worker (dis)abilities, as well as adjustments at work. Subjects are also asked for their opinion on working conditions and the social atmosphere at work. TNO has validated the questionnaire in several other research projects^{7,11,13} and reported good reliability. In the present study, we used the sections related to the amputee employees' opinions about their work and the social atmosphere at work and about patient characteristics and amputation-related factors. The topics referring to job latitude, deci-

sion making, and demands are based on the Job Control/Job Demands Model¹⁴ and the Job Characteristics Model.¹⁵ Questions in this section of the questionnaire can be analyzed individually; they investigate 8 aspects of vocational satisfaction: job content, work organization, physical working conditions and safety, management and colleagues, physical and mental exertion, relationship between work and private life, appreciation and job perspective, and general judgment of the job.¹⁶ All questions have the answer categories yes or no, except for the last question about general judgment of the job. This latter question has 4 answer categories: good, reasonable, moderate, and bad. This result was dichotomized into 2 categories: good job satisfaction or insufficient job satisfaction, the latter being a combination of the last 3 categories (reasonable, moderate, bad).

The second questionnaire was a general health questionnaire (RAND 36-Item Health Survey [RAND-36], Dutch version) for the measurement of health status (psychologic, physical, social, overall well-being). The RAND-36 is a short version of the RAND Health Insurance Study Questionnaire and is similar to the Medical Outcomes Study 36-Item Short-Form Health Survey.¹⁷⁻¹⁹ It measures health perception on 9 multi-item dimensions: physical functioning, social functioning, physical role restriction, emotional role restriction, mental health, vitality, pain, general health, and health change. A lower score on the RAND-36 means a worse health experience.

The control subjects received the same questionnaires, but the first questionnaire only consisted of the sections regarding opinions about their work, the social atmosphere at work, and subject characteristics. The RAND-36 was also sent to the control subjects.

Indicators of Job Dissatisfaction Among Amputee Participants

Amputee participants were divided into 2 categories: those with good general job satisfaction and those with moderate, reasonable, or low job satisfaction (designated insufficient job satisfaction). Based on literature and clinical experience with persons who had a lower-limb amputation, we studied the following factors for their relationship to job dissatisfaction of amputee participants.

Demographically related factors. These factors are age at the time of study, age at the time of amputation, gender, and education level. Education level was divided into lower, intermediate, and higher education.

Amputation-related factors. These factors are comorbidity, amputation level, stump and/or phantom pain, wearing comfort of prosthesis, walking distance, mobility level, job category at the time of study, number of restrictions in job tasks, modifications in the workplace, and wish for (more) modifications in the workplace.

We dichotomized the following factors: comorbidity (yes vs no), amputation level (above-knee vs Syme's amputation up to and including a knee disarticulation), stump and/or phantom pain (severe vs mild), wearing comfort (bad/insufficient vs sufficient/good), and walking distance (<500m vs >500m). The mobility level was scored as the number of mobility items (walking, sitting down and standing up from a chair, stooping and rising back up, keeping balance, making accurate movements with feet and legs, squatting and kneeling, walking stairs) for which patients reported restrictions. Seven job categories could be distinguished: agrarian, trade or industrial, transport, administrative, commercial, servicing, and other scientific or technical. Restrictions in job tasks were calculated by comparing problems of patients in several activities of daily living (ADLs) with problems in comparable tasks within their

Table 1: Characteristics of Control Subjects and Amputee Employees

	Control Subjects (N=144)	Amputee Employees With Control Subject (N=144)	All Working Amputee Patients (N=413)
Mean age \pm SD (y)	41.0 \pm 8.3	42.6 \pm 8.4	43.3 \pm 9.5
Men/women (%)	76/24	78/22	81/19
Present type of job (%)			
Agrarian	2	1	3
Trade or industrial	20	21	24
Transport	10	8	9
Administrative	17	22	20
Commercial	10	9	10
Servicing	7	9	11
Other scientific/technical	33	29	23
Education level (%)			
Low	15	26	34
Intermediate	48	38	41
High	37	37	25
Mean age \pm SD at time of amputation (y)		21.4 \pm 10.5	22.0 \pm 11.0
Reason amputation (%)			
Trauma		66	69
Cancer		15	15
Vascular		4	3
Diabetes		0	1
Other		15	13
Amputation level (%)			
Transtibial		49	48
Transfemoral		35	34
Knee		12	11
Hip		3	3
Pelvis		1	2
Ankle		0	2

NOTE. Amputees of the defined study group and all working amputees in the full cohort. Abbreviation: SD, standard deviation.

job. TNO has defined 4 categories: (1) no difficulty with a certain job task, ie, the job task does not relate to an activity that causes a problem in daily living; (2) normal difficulty with a certain job task, ie, someone has no difficulty with the task in daily living, but experiences difficulty with the task at work (employees without a handicap will have difficulties with the task as well); (3) adjusted job task, ie, someone has to do an activity at work that, in daily living, creates difficulties but he does not mention problems with the task at work; and (4) insufficiently adjusted job task, ie, someone has difficulties with doing a certain ADL and experiences difficulties with the comparable activity at the workplace. This was defined as a restriction in job tasks. The number of restrictions was included in the analysis.

Patients also reported whether modifications had been made in their workplace and whether they would like to make (more) adjustments to adapt their workplace to the limitations of their amputation.

Analysis

Descriptive statistics were performed by using the Statistical Product and Service Solutions software.^a For the most part, percentages are presented. Differences in the indicators between satisfied and dissatisfied subjects with limb loss were tested by using univariate logistic regression analysis (significance level, $\alpha=.05$). We used forward multivariate logistic regression to test the relationship of several indicators with the job dissatisfaction of amputee patients. Factors were tested in this analysis if the *P* value of the univariate regression analysis was $\leq .10$.

We looked at how accurately the multivariate logistic regression model, which included the independent variables, classified amputee employees at risk for insufficient job satisfaction, compared with a model that had no independent variables (prediction made by chance). This result was expressed as the sensitivity and positive predictive value of the model. The "sensitivity" is the proportion of participants with insufficient job satisfaction who are predicted to have an insufficient job satisfaction. The "positive predictive value" is the percentage of participants predicted to have insufficient job satisfaction who indeed reported being insufficiently satisfied with their workplace.

Differences between amputee employees and controls in the section on subjects' opinions about their work and the social atmosphere at work were calculated by using the McNemar test for matched pairs. If statistical significance was reached ($\alpha=.05$), we defined differences in item scores as clinically relevant if they were at least 5%. Differences in the scores of the RAND-36 were calculated by using the paired *t* test ($\alpha=.05$).

RESULTS

Matching Procedure and Representativeness

Table 1 shows that the matching procedure was executed successfully by the amputee participants. No relevant differences could be shown in gender, age, or type of job between amputee and control subjects. A difference existed between the education level of both groups, but this was not a criterion for matching.

Table 2: Relation Between Demographic and Amputation-Related Factors and Job Dissatisfaction in the Amputee Employee Group

Variables	Job Satisfaction Good (n=102)	Job Satisfaction Insufficient (n=42)
Mean age \pm SD at time of study (y)	42.3 \pm 7.9	43.1 \pm 9.5
Men (%)	78	76
Mean age \pm SD at time of amputation (y)	21.9 \pm 10.0	20.1 \pm 11.6
Education level (%)		
Low	24	31
Intermediate	39	33
High	37	36
Comorbidity present (%)	28	50*
Knee and lower level of amputation (%)	62	57
Severe phantom and/or stump pain (%)	16	18
Bad/insufficient wearing comfort (%)	6	12
Walking distance <500m (%)	18	24
Mean mobility level \pm SD	2.1 \pm 1.9	3.1 \pm 2.2*
Type of job at the moment (%)		
Agrarian	1	2
Trade/industrial	24	14
Transport	6	12
Administrative	21	26
Commercial	10	7
Servicing	8	12
Other scientific/technical	31	26
Mean no. of restrictions \pm SD in job tasks	0.9 \pm 2.0	1.7 \pm 2.8
Modifications in the workplace (%)	25	35
Wish for (more) modifications in the workplace (%)	10	30*

NOTE. Relations were derived by univariate logistic regression.

* Significant relationship ($P < .05$).

In the present study, we only analyzed the data of the 144 amputee employees who met the inclusion criteria and who could be compared with matched, able-bodied control subjects. We checked the representativeness of this selected group of 144 amputee participants for the whole group of 413 working amputee patients who returned the questionnaire. No differences could be shown, except for the participants' somewhat higher education level. In all other aspects, the sample with a matched control was representative of the entire sample of amputees who returned the questionnaire.

Indicators of Job Dissatisfaction Among Amputee Participants

Seventy percent of the subjects with a lower-limb amputation judged their work life as good and 30% judged it unsatisfactory. Table 2 shows the relationship between job dissatisfaction and demographic and amputation-related factors. Three factors had a statistically significant relation with job dissatisfaction: comorbidity, mobility level, and the wish for more modifications in the workplace. These significant factors were included in the forward multivariate regression analysis. A fourth factor, the number of restrictions in job tasks, was added. Its P value was less than .10 in relation to job dissatisfaction. We found 2 factors that were significant indicators of general job dissatisfaction: the wish for (better) modifications in the workplace and the presence of comorbidity.

The sensitivity of the model—with the 2 variables included—increased from 0% to 18%. The predictive value increased from 0% to 64%.

Job Characteristics and Job History of Amputee Participants and Control Subjects

The number of hours worked weekly was comparable in people with (37.5h/wk) and without (39.3h/wk) limb loss. Most

subjects had full-time employment (in the Netherlands, a full-time job is 36–40h/wk). No relevant differences existed in the job history of subjects with and without an amputation with respect to how long they had been working at their present job (12.5y for amputees, 10.5y for controls), the number of employers that subjects had had (mean, 3 for both amputee participants and controls), and the percentage who had received supplementary education during their career (71% for both amputee participants and controls). In addition, we asked whether subjects had ever been unemployed against their wishes. Twenty percent of the amputee participants answered this question affirmatively, compared with 15% of the control subjects. In the type of work done by the subjects in the past, only small differences existed between both groups. Forty-two percent of the amputee participants and 39% of the controls had done physically strenuous work; mentally demanding work had been done by 62% of the amputee participants and 58% of the control subjects.

Job Satisfaction of Amputee Participants Compared With Controls

Thirty percent of the subjects with an amputation and 46% of the controls judged their work as unsatisfactory. This difference was statistically significant ($P = .003$). Table 3 shows the item scores of the section of the questionnaire that addressed perceptions about working conditions and the social atmosphere at work. Apart from the difference in general vocational satisfaction, significant differences between amputees and controls existed on the items "often hindered by failures of others" and "much hindrance due to fluctuations in temperature." Amputee participants scored significantly better on both items than control subjects. The differences were also clinically significant.

Table 3: Percentages of Negative Judgments on Working Conditions and Social Atmosphere at Work of Amputee Participants and Controls

	Amputee Participants (N=144)	Controls (N=144)
General job judgment insufficient (%)	30	46*
Job content (%)		
Insufficient education for job	8	9
Insufficient variability in job	7	6
Work is mostly uninteresting	10	13
Mostly no pleasure in work	5	7
Work too simple	9	13
Physical and mental exertion (%)		
Work physically very demanding	19	15
Work mentally very demanding	75	69
Often working under time pressure	62	66
Work often too tiring	14	20
Often problems with tempo/busyness	11	13
Should go easy on work	31	24
Work organization (%)		
Work in general not well organized	23	30
Insufficient consultation with others	11	7
Often hindered by unexpected situations	28	35
Often hindered by failures of others	18	38*
Often hindered by absence of others	19	18
Management and colleagues (%)		
Bad internal atmosphere at work	11	13
Often annoyed about others	19	24
Insufficient daily supervision	28	38
Supervisor has a bad image of your work	22	31
Supervisor does not take your opinion into account sufficiently	23	27
Relationship work-private life (%)		
Unfavorable influence of work on private life	16	26
Appreciation and job perspective (%)		
Insufficient appreciation in the firm	16	22
Insufficient payment for this job	31	40
Bad job prospects in this job	24	34
Physical working conditions and safety (%)		
Much hindrance because of temperature fluctuations	11	21*
Much hindrance because of dry air	15	18
Much hindrance because of lack of fresh air	19	24
Much hindrance because of noise	8	11
Much hindrance because of stench	2	4
Safety at work insufficient	6	6

* Significant difference $P < .05$ tested with the McNemar test (only data of complete pairs are mentioned).

On the 31 items, 58% of the amputee participants had 5 complaints or fewer, and 42% had more than 5 complaints. Forty-four percent of the control subjects had 5 complaints or fewer, and 66% had more than 5 complaints.

Health Experience of Amputee Participants and Controls

Table 4 shows the score results on the RAND-36 for subjects with and without limb loss. Significant differences were shown on the subscales of physical functioning, physical role restrictions, and pain. All other subscales showed comparable scores for amputee participants and controls. On the subscale physical functioning, amputee participants scored worse on all items. The difference on the subscale physical role restrictions was mainly explained by amputee participants having a worse score on the items about restrictions and difficulties in work and recreational activities. On the subscale pain, amputee participants showed mild complaints of pain more often than controls and were mildly restricted by the pain more often.

Table 4: Health Experience of Amputee Participants in Comparison With Healthy Control Subjects as Measured by Using the RAND-36

RAND-36	Amputee Participants (mean \pm SD)	Control Subjects (mean \pm SD)
Physical functioning	62.6 \pm 25.0	95.0 \pm 16.4*
Social functioning	86.6 \pm 19.7	89.6 \pm 16.1
Physical role restriction	86.0 \pm 28.6	94.3 \pm 17.1*
Emotional role restriction	92.0 \pm 22.4	93.8 \pm 19.4
Mental health	80.1 \pm 15.3	80.2 \pm 13.9
Vitality	69.0 \pm 18.2	69.2 \pm 16.5
Pain	80.4 \pm 20.1	91.3 \pm 14.6*
General health	76.5 \pm 17.3	76.6 \pm 16.2
Health change	52.3 \pm 17.0	50.4 \pm 13.9

* Statistically significant difference ($P < .05$) between amputee participants and their control subjects.

DISCUSSION

All data were obtained by self-report questionnaires. They reflect the personal judgments of amputee participants and healthy colleagues regarding their work environment and their health experience. In the present study, we did not ask the employers for their opinions about the work capacity of both groups. From research done by TNO, we know that employers often judge chronically disabled people more negatively than their healthy colleagues.²⁰

The matching procedure was done by the amputee participants themselves. Matching for age, gender, and type of job was executed correctly. Other sources of selection bias of control subjects cannot be completely ruled out. In our research, however, this matching procedure was the only opportunity to form a control population with the same type of job diversity as the amputee population. For example, all reference data¹⁶ about the questions concerning subjects' opinion of their work and the social atmosphere at work were available only for specialized groups of working people within 1 specialized branch of work.

Only a portion of the amputee respondents proposed a healthy colleague to participate in the study (144/413). Because this portion of the amputee participants did not differ from the whole group of working amputee participants who returned the questionnaire, except for education level, bias seems unlikely.

Job satisfaction of amputee participants was good in 70% of cases. A relationship was shown between job satisfaction and the wish to adjust the workplace (better) to the limitations presented by the amputation and the presence of comorbidity. The model with the 2 variables included had an apparently higher sensitivity and predictive value of insufficient job satisfaction than that without the 2 variables included.

These findings can influence the reintegration policy of people with a lower-limb amputation. Rehabilitation specialists have a responsibility to help patients attain a good, functional, job reintegration. In previous research,¹ we showed that many amputee employees (27%) would like their work to be (better) adjusted to the limitations of their amputation. The relationship between insufficient modifications in the workplace and job dissatisfaction again emphasizes the importance of paying attention to adjustments in the workplace in the process of reintegration. Rehabilitation specialists, together with the amputee patient, should make a detailed inventory of the patient's functional capabilities. This should be compared with the functional demands of the job the person is doing or would like to do. The necessary modifications should be made as soon as possible in the reintegration process to prevent delay in returning to work. After some time, the working situation and job satisfaction of the person with limb loss should be evaluated, and the modifications should be adjusted to a possibly changing situation. As an employee with an amputation ages, more physical problems can develop,¹ and more modifications might be needed. As we showed in former research¹ and as is stated by Yelin,²¹ not only material modifications are important. For disabled people, the ability to control the pace and scheduling of work activities is even more important than it is for able-bodied people. We will study this aspect in further research.

Subjects with an amputation in combination with other comorbidity are at risk of having lower job satisfaction. Additional attention should be paid to the working situation of this group of people. Specialized vocational rehabilitation programs might be needed for patients with multiple problems. In these programs individual reintegration routing is important, and disabled people should be supervised from amputation to resumption of work as well as after their return to work. A

better cooperation between rehabilitation specialists and medical doctors is necessary. In addition, rehabilitation specialists may focus too much on the amputation and pay less attention to other diseases and disabilities. Our research shows that treating comorbidity may be important for a successful job reintegration with good job satisfaction.

Despite our results, an important part of the reason for job satisfaction remains unclear. This part may be explained by other factors eg, the motivation of the amputee employee, autonomy in the workplace, job control, and relationships with colleagues.²¹ These should be studied in further research.

To compare job satisfaction between subjects with and without limb loss, we used more than statistical significance. We defined what we thought to be a clinically relevant difference between both groups. Because almost no information is available on this topic, the definition was based mainly on the authors' clinical experience. More research is needed to find general definitions of clinically relevant differences for aspects related to different outcome measures.

We found no relevant differences in job characteristics and job history between subjects with and without an amputation. People with an amputation showed greater job satisfaction (70%) than did the able-bodied control group (54%). The better general job satisfaction of subjects with a lower-limb amputation existed despite their worse health experience compared with controls, especially on the physical subscales of the RAND-36. Higher job satisfaction despite a worse health experience was also found in previous studies of other chronically disabled people.⁷ Gerhards et al¹⁰ also found higher job contentment in people with an amputation than healthy people despite lower occupational status. A good explanation for this phenomenon is difficult to find, but 2 factors may be important.

In the first place, a person who has an amputation experiences being at work as valuable, and this perception may positively influence opinions about the working situation. Employees with an amputation might even be less critical toward their working conditions than their healthy colleagues.

In the second place, when we examined whether multiple working conditions could explain the difference in job satisfaction between amputee patients and healthy colleagues, we found very few differences between the groups (see table 3). Amputee employees reported fewer hindrances caused by the failures of others, and they had fewer hindrances from temperature fluctuations in the workplace. On all other items, no differences were significant, although this was approximated on the items insufficient daily supervision, supervisor has a bad image of your work, and unfavorable influence of work on private life. Apparently, other person- or work-related aspects might play a role to be studied in future. For example, the factors autonomy and ability to control work scheduling were only marginally represented in the questionnaire and may be important in the explanation of job satisfaction. We do not know any other study in which multiple working conditions were studied in relationship with job satisfaction of amputee employees and healthy colleagues.

The number of people who reported complaints differed between the 2 groups. In the amputee group, the number of complaints per subject (58%, 5 or less) was less than the number of complaints per subject in the control group (44%, 5 or less). This means that in the amputee group many people expressed few complaints, whereas in the control group fewer subjects complained, but they had more complaints each. Evidently, a great portion of our amputee subjects had some problems in their job, and more detailed information is necessary to know how these problems can be solved.

CONCLUSION

Indicators of job dissatisfaction of people with a lower-limb amputation are (1) the wish for (better) modifications in the workplace and (2) comorbidity. The rehabilitation specialist and the patient have to work together early in the reintegration process to adjust the functional capabilities of an individual better to the functional demands of the job to obtain optimal job satisfaction. Specialized vocational rehabilitation programs can benefit those persons who have an amputation in combination with other disabilities.

Despite a worse physical health experience, people with limb loss tend to be more content with their current occupational status than their healthy colleagues. This reflects their appreciation of job reintegration. However, many amputee employees report some problems with their working conditions. These problems may be alleviated if more information becomes available about factors that explain the difference in job satisfaction between people with and without limb loss.

Acknowledgments: We acknowledge Jannie Kootstra, research nurse, for her assistance in the recruitment of subjects and in organizing, sending, and receiving of questionnaires, and Treanne Vrieze for her assistance in contacting all the patients. We acknowledge Eric van Sonderen for his advice in the statistical analyses. We also thank Frank Andries (TNO) for advice about the use of the questionnaire and the orthopedic workshops for the recruitment of patients.

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