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**The Profile of Patients' Occupational  
Health in Primary Care**

**HEF/03/10**

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# EXECUTIVE SUMMARY

## OBJECTIVES

To provide quantitative and qualitative data to answer the following questions;

1. Why do GPs and practice nurses not take greater account of occupational issues in their day to day contact with patients of working age?
2. Why has patient's occupational health failed to gain a higher priority amongst primary care managers and planners?
3. What are the professional, social, and economic pressures that give occupational health a low priority?
4. What could HSE do to turn these pressures around so that occupational health receives a higher priority and greater account is taken of the impact of work on health to the benefit of primary care patients, workers, and employers?

## STUDY DESIGN

In this study, qualitative data was collected using focus groups with three groups of primary care sector professionals, general practitioners, primary care centre nurses, and primary care centre managers. Quantitative data was collected nationally from 295 GPs using a postal questionnaire. The quantitative data was analysed using appropriate statistics in which the prevalence of a response (or opinion) was expressed in terms of frequencies for each item and Mantel-Haenszel common odds ratio estimates.

Responses to the following general questions were collected from the focus groups and postal questionnaire:

- Were patient occupations recorded by the GP's?
- Were occupational causes of a patient's illness routinely explored?
- Was sufficient training provided within the medical curriculum (or professional training) to address occupational health problems?
- With what frequency were occupational health problems encountered?
- What was the best role for primary care in addressing occupational health problems?
- What were the perceived obstacles to improving occupational health provision for patients?
- Which services were used by GPs to refer patients with occupational health problems?
- What was the level of occupational health provision for primary care staff?

The questions used in the focus groups, and for the questionnaire, were refined during a workshop held with the study group.

## MAIN FINDINGS

The focus groups identified a number of specific areas for further investigation in the quantitative phase of the study. Of specific concern was the lack of professional training and knowledge in occupational health (occupational health being regarded as a specialism in itself) and access to appropriate routes for referral of patients. Additionally, the groups identified that although primary care had a role to play in relation to a patients occupational health problems, employers also needed to take more responsibility, and an increase to the state provision for these patients was required. It was evident that practice nurses and managers were key in

providing occupational health capabilities within the primary care setting if provided with appropriate resources and support. Issues were explored in more detail in the postal survey, which additionally provided quantitative data.

It was generally reported that GPs and practice nurses take a focused approach to exploring patients' occupation, (when it was considered relevant to the presenting complaint) although their lack of occupational health knowledge left them poorly equipped to deal with some of the issues that arise. Occupational health was viewed as one amongst many other key social health policies that they were expected to deliver within the framework of primary care. Amongst the primary staff questioned, occupational health was regarded as a speciality and because of heavy workloads, most stated that they would prefer to refer such patients to specialist centres. However these specialist services were not generally available, and if they were available, they were insufficiently financed and poorly advertised. All three groups said that they would be more willing to record occupational health information if there were better procedures for doing this.

It was considered that the roles of the employer vs the primary care staff were not well defined. It was frequently reported that employers take insufficient responsibility for the health of their employees and that employers often transferred their responsibility onto an over stretched primary care service. Poor routes of communication with the employer often contributed to this problem. The MED 3 sickness certification was frequently stated as an obstacle. The practice managers also reported that poor financial resources limited their options for dealing with occupational illness. Referral of patients to specialist services (particularly for mental health and musculoskeletal problems) usually encountered long delays; these were the most frequently encountered occupational health problems.

The groups were asked about the professional, social, and economic pressures that result in occupational health being given a low priority in their work. Occupational health was regarded as a specialism by most GPs and so they were less likely to allocate time and acquire the required resources to deal with these problems. The pressure to deliver so many other health priorities prevented them from investigating occupational health needs. With regard to social pressures the primary healthcare staff faced ethical barriers when investigating occupational ill health. For example, whether they should communicate with the employer, particularly when there were potential conflicts of interest between the employer and employee, and what should they do when confronted by guilty knowledge? These issues were particularly relevant to sickness certification and 'fitness to work'. There were economic pressures that limited the uptake of specialist services, and that stopped GP's from investigating the full history of occupational illness. Specialist services were usually expensive and 'ring fenced' funding was need for these services at national and regional levels.

When asked what HSE should do to address these problems, the participants suggested several areas for improvement. Systems should be developed to help primary care practitioners record and evaluate occupational health without adding a burden to hard-pressed resources. There should be improved access to information and advisory services for occupational health (e.g., information sheets and e-learning resources). Information about services for occupational health (e.g., Employment Medical Advisory Service, Occupational Health Advisory Service and Department for Work and Pensions "Long-term ill or disabled support") should be improved and a simple screening questionnaire developed so that primary health care staff can identify patients with occupational health problems. The participants also called for HSE to campaign for change in key areas. As a major stakeholder, HSE should support national initiatives to improve resources for occupational health within primary care and especially through specialist centres. Priority should be given to mental health, stress, and musculoskeletal problems with counselling and physiotherapy services seen as key resources. HSE should support initiatives to develop occupational health resources that can be shared with large primary care trusts (PCT)

with speedier access to specialist services. In partnership with the NHS and Universities, there should be greater advocacy for inclusion of occupational health within the medical curriculum for health care professionals. There also needs to be better support for training and professional development in occupational health for primary care staff, for example use of the Protected Learning time initiative (PLI) scheme. HSE also needed to work with other government departments to clarify the role of employers, company occupational health providers, and GP's (particularly for the MED-3 sickness certification and decisions about fitness for return to work).

## **RECOMMENDATIONS**

- 1) The results of this survey suggest that practice nurses and practice managers are best placed to respond to the occupational health agenda if given the appropriate support and resources. Consequently further work should be undertaken to identify the needs and obstacles for these groups in delivering services to patients with occupational health needs.
- 2) The access for Primary health care staff to information and specialist occupational health advice needs to be improved. In the long term changes to the medical curriculum are required but in the short term consideration should be given to supporting the following:
  - Better information on routes for referral and access to specialist occupational health services
  - Development of simple screening questionnaires to highlight those patients with work-related ill-health.
  - To examine practical ways to record the patients occupational health history within the existing structures for recording a patients medical history
  - On-line resources for occupational health routed through the existing major providers to primary health care staff.
  - Resources to support continuing professional development in partnership with the National Health Service, Department for Work and Pensions and other government departments
  - Resources to support the use of specialist services (in occupational health) for primary care practice.

# 1 INTRODUCTION

Illness resulting from a patient's work, and the impact of ill-health on a patient's capacity for work, are important issues for primary health care. The potential of primary care (as a setting for intervention) to improve the health of the workforce has been evident for many years (Vaughan, 1960) in both industrialised countries and transitional economies (Kocks and Ross 1995).

Research over the past twenty years has shown that work plays a major role in the health of adults, both as a cause of ill health (Harber 1994 D'Auria 1989, Jones 1995) and also as a potential health promoting activity. Additionally there is also a renewed interest in maintaining the working capacity of employees to increase productivity and reduce business costs. Information regarding the influence that work can play on the health of adults has increased interest in the role that primary health care could play in illness prevention (CEC). Recently the Health and Safety Commission in conjunction with other Government bodies produced an occupational health strategy 'Securing Health Together'. Information contained within this strategy includes specific recommendations for measures at primary health care level to contribute to the common goal of reducing work-related ill-health and sickness absence (OHAC, 1999).

From the literature it is suggested that primary health care generally lacks (with a few exceptions) a systematic role in the prevention of ill-health or in the rehabilitation of adults back to work even in developed countries (Rasanen 1993). Published reports emphasise that primary health care professionals face many difficulties in realising this potential for addressing work-related health issues. This report contains results from focus groups (aimed at key primary health care staff), which address issues surrounding the provision of occupational health. Additionally it highlights results from a questionnaire addressing the same issues, which was circulated to a random sample of UK GPs. The report also contains a review that examines the obstacles identified in the few well-documented reports on this subject, and considers the solutions that have been proposed or adopted to overcome these problems. The review highlights the proposals (or examples) that demonstrate most promise to address this issue, and also identifies outstanding problems still to be resolved. Yassi (1990) suggested that given the current provision of occupational health services in the workplace, primary health care is the only means by which most of the workforce will receive occupational health support. The problem of how best to deliver this objective has still to be addressed.

## 1.1 AIMS AND OBJECTIVES

The aim of this project as identified in the invitation to tender (ITT) document is to provide HSE with qualitative and some quantitative data to answer the following questions:

- Why do GPs and practice nurses not take greater account of occupational issues in their day to day contact with patients of working age?
- Why have patients' occupational health issues failed to gain a higher priority amongst primary care managers and planners?
- What are the professional, social, and economic pressures that give occupational health a low priority?
- What could HSE do to turn these pressures around so that occupational health receives a higher priority and greater account is taken of the impact of work on health to the benefit of primary care patients, workers, and employers?

## **2 METHODOLOGY**

### **2.1 STUDY DESIGN**

A comprehensive range of information sources was used to inform the design of the study. In order to collect qualitative information regarding primary care, we held a series of focus groups for stakeholders, which consisted of GPs, practice nurses and practice managers. This qualitative approach was supplemented by the collection of quantitative data reported on self-administered questionnaires that were mailed to a random sample of GPs in the UK. This enabled a blend of quantitative data (from the questionnaires) and descriptive qualitative data (from the focus groups) to be collected.

Findings from each stage of the research were used to inform the next stage of data collection. The literature review was used to identify appropriate focus group prompt questions, and the focus groups findings were used to inform the content of the GP survey questionnaire.

### **2.2 FOCUS GROUPS**

The particular strengths of focus groups is that they identify opinions on specific topics of interest and capitalise on group interactions to provide insights into the opinions and experiences of peer groups (Morgan 1997). To develop a framework for the focus group, a study team workshop was held first to agree the most appropriate format for the focus groups. The information gathered from the literature review was also combined with information and experience provided by the study group.

#### **2.2.1 Prompt questions**

Information gained from the literature review was used to inform the development of the focus group prompt questions. Early drafts of the prompt questions were sent to the HSE project leader and project team. They were also piloted with 2 Sheffield GPs. Once all comments had been received and addressed, a final version of the questionnaire was produced (See Appendix 2 for copy of questionnaire). The questions were open allowing the participants to speak freely on the topic and enabling the researchers to explore their opinions and attitudes in greater detail.

The prompt questions explored a range of issues identified as relevant to occupational health provision for patients in primary care, including: their perception of occupational health; the problems they encounter; whether occupational health should be addressed in primary care; perceived barriers and possible solutions. The issue of occupational health provision for staff in primary care was also addressed (See appendix 2 for a copy of the focus group prompt questions).

#### **2.2.2 Participants**

The first set of stakeholders was drawn from the Sheffield area, and the second set from Manchester. Care was taken to ensure that the focus group representatives were drawn from a diverse range of areas, both geographically and demographically. Participants were randomly selected and contacted via a phone call by a member of the study team. The study was explained, and individuals were invited to attend the focus groups. Two separate focus groups were conducted for each stakeholder group (GPs, practice nurses and practice managers) in both Sheffield and Manchester. In total 22 GPs, 25 practice nurses and 24 practice managers participated in the focus groups.

#### **2.2.3 Data collection**

To encourage uninhibited discussion, separate focus groups were held for GPs, practice nurses and practice managers. Between six to nine participants attended each group, and in total 71 participants attended the 12 focus groups. Each focus group lasted for approximately an hour.

Two experienced HSL researchers attended each session, a facilitator to introduce discussion questions and probe issues raised, and a note taker to maintain a written record of each discussion. Discussions were also audio taped with the permission of those present. Participants were assured that no individuals or practice would be identified in connection with the findings.

#### **2.2.4 Data analysis**

The written account of each discussion was subsequently typed up and formed the basis for analysing the focus group discussions. The audio tape recordings were also analysed to verify the written account of discussions and obtain verbatim quotes to illustrate the findings. Two HSL researchers independently analysed the written accounts of each focus group discussion to identify the key themes/issues emerging within each group. The key issues for each group of stakeholders (GPs, practice nurses and practice managers) were then collated to provide a combined account of the common issues identified across the groups, noting any specific differences, for example between the Sheffield and Manchester groups.

### **2.3 QUESTIONNAIRE**

#### **2.3.1 Questionnaire design**

Information obtained from the focus groups was used to inform the development of the GP survey questionnaire. The questionnaire contained questions on topics such as:

- What occupational health problems are encountered in patient consultations?
- Where they obtained information on occupational health?
- What barriers prevent them from addressing occupational health issues?

Early drafts of the questionnaire were sent to the HSE project leader and project team. The questionnaire was also piloted with 4 GPs to assess its face validity and the length of time it would take to complete. Once all comments had been received and addressed, a final version of the questionnaire was produced (See Appendix 3 for copy of questionnaire).

#### **2.3.2 Data collection**

It was stressed that the responses to the questionnaire were totally confidential, and would not provide any means of identifying the respondent. Following piloting with XX GPs, the questionnaire was sent by post to a random selection of 1000 UK GPs. (See Appendix 4 for copy of the accompanying letter). The respondents were requested to return the completed questionnaire to the HSL research team by use of a stamped addressed envelope provided.

#### **2.3.3 Data analysis**

The responses to each questionnaire item were entered into a SPSS statistics spreadsheet (statistical package for social scientists version 10, SPSS incorporated, Chicago USA) This enabled quantitative analysis of each response such as frequencies for each item and the formation of bar charts, as appropriate. Analysis was additionally performed by cross tabulation with Mantel-Haenszel common odds ratio estimate.

## 3 RESULTS

### 3.1 FOCUS GROUPS

#### 3.1.1 Participants

Two separate focus groups were conducted for each stakeholder group (GPs, practice nurses and practice managers) in both Sheffield and Manchester. In total, 22 GPs, 25 practice nurses, and 24 practice managers participated in the focus groups (table 3.1). Each participant was asked to provide information regarding the number of patients registered at the practice and how many practice nurses and GPs worked at the practice (table 3.2). There was no significant difference in the mean number of GPs or patients per practice between Sheffield and Manchester ( $p= 0.27$  and  $p=0.82$  respectively). However, the mean number of nurses employed at practices in Sheffield was significantly higher than that of Manchester ( $p=0.005$ ).

**Table 3.1.** Focus group participants

	SHEFFIELD	MANCHESTER	TOTAL
PRACTICE MANAGERS (N)	8	16	24
PRACTICE NURSES (N)	14	11	25
GPs (N)	10	12	22
TOTAL	32	39	71

**Table 3.2.** Practice details

	NURSES (N)/PRACTICE		GP (N) /PRACTICE		PATIENTS (N)/PRACTICE	
	SHEFFIELD	MANCHESTER	SHEFFIELD	MANCHESTER	SHEFFIELD	MANCHESTER
MEAN	3	2	5	4	7386	7545
MEDIAN	3	2	4	4	7400	7000
MAX	7	4	9	7	13000	12000
MIN	1	1	2	1	3100	1800

#### 3.1.2 Demographics

Each focus group participant was asked whether they had any involvement in occupational health provision. The responses varied, as some participants were involved in providing occupational health for the practice staff, some stated they had minimal or infrequent involvement (but did not expand any further) and some were involved in occupational health provision for external contractors. For the purpose of the demographic analysis any positive response was scored as a 'yes'. It is possible, however, that this has led to an overestimate of the true degree of involvement of primary health care workers in occupational health; particularly with regard to practice managers.

Each participant was also asked whether they were employed full-time or part-time, and whether the practice employed a practice manager. Table 3.3 summarises the responses.

**TABLE 3.3. PARTICIPANT DEMOGRAPHICS (UPPER VALUES SHOWING THE NUMBERS AND THE LOWER VALUE THE PERCENTAGE)**

	SHEFFIELD			MANCHESTER			TOTAL		
	PN	PM	GP	PN	PM	GP	PN	PM	GP
<b>ANY INVOLVEMENT WITH O/H</b>	7/14 50%	2/8 25%	2/5 40%	5/11 45%	11/12 92%	8/13 62%	12/25 48%	13/20 65%	10/18 56%
<b>PRACTICE MANAGER EMPLOYED</b>	14/14 100%	8/8 100%	10/10 100%	11/11 100%	10/10 100%	11/11 100%	25/25 100%	18/18 100%	21/21 100%
<b>FULL TIME WORKER</b>	3/14 21%	6/8 75%	4/5 80%	3/11 27%	14/16 88%	13/13 100%	6/25 24%	20/24 83%	17/18 94%

O/H=Occupational Health  
 PN=Practice Nurse  
 PM=Practice Manager  
 GP=General Practitioner

## **3.2 DISCUSSION OF FOCUS GROUP FINDINGS**

The main points from the focus groups are listed according to each topic covered. The full results can be found in Appendix 6.

### **3.2.1 Occupational Health problems**

All three stakeholder groups were in agreement regarding the main occupational health problems presented by primary care patients: musculoskeletal disorders & mental health problems (e.g. stress, depression). It is noteworthy that both of these are currently the most common types of work related health problems affecting the British labour force, accounting for 13.4 and 12.3 million working days lost in 2001 respectively,<sup>1</sup> and are identified as priority hazards in HSE's Revitalising Health and Safety targets. It was felt to be difficult to quantify the extent to which primary care patients present with occupational health problems, as this information is not recorded on patient information systems.

### **3.2.2 Involvement in addressing occupational health**

GPs appear to take a focused approach to exploring patients' occupation, where it is considered to be relevant to the presenting complaint. Practice nurses indicated that they explore occupation routinely as part of establishing a holistic view of the patient. One potential weakness of the focus group methodology is that where one participant reports such an example of good practice, others may be reluctant to admit that they do not do this. The additional information provided by the anonymous individual questionnaire survey of GPs will have helped reduce this type of bias, but it may be important to conduct a similar exercise among the other stakeholder groups.

Practice nurses also have greater involvement in chronic disease management and health promotion. Practice managers have limited direct patient contact but have a potentially significant role in relation to patient education, health promotion and access to resources.

Arguments were presented by GPs for and against their involvement in MED3 Sickness certification. The main reason for opposition appeared to be the perception that they are not always the best qualified to make judgements regarding patients' fitness for work. However, arguments in favour of GPs involvement in sickness certification included the fact that patients have to come to the surgery and that the GP is made aware they are sick. In addition, it makes them discuss the patient's work and can provide an opportunity for contact with their employer.

### **3.2.3 Occupational health education and training**

GPs and practice nurses indicated that there is minimal occupational health coverage in their education and training, except for some conditions with obvious work related causes. Their lack of occupational health knowledge makes them feel ill equipped to deal with some of the occupational health related demands they encounter. This is consistent with the literature, which indicates that occupational health receives little coverage in the basic medical and nursing curriculum (Seaton 1995, Griffin 1992) and postgraduate GP vocational training schemes (Parker 1996).

### **3.2.4 Role of primary care in addressing occupational health problems**

The three stakeholder groups considered that primary care has a role to play in relation to addressing occupational health problems for patients, but that this is a limited role and employers need to take more responsibility and/or have increased state occupational health provision for patients without access to employer provision. It was felt there is need for greater

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<sup>1</sup> Health and Safety Statistics Highlights 2001/02 MISC472 HSE Books 2002

clarity regarding the respective roles and responsibilities of employer occupational health services and primary care/NHS services.

### **3.2.5 Barriers to addressing occupational health**

#### **3.2.5.1 Knowledge**

The combination of limited general occupational health knowledge and specific knowledge of the patient's workplace makes it difficult for GPs and practice nurses to assess and advise on occupational health problems, particularly judging fitness for work. This issue is also highlighted in the literature (D'Auria 1989, Dickenson 1985, Memel 2000) and has promoted discussions over the how to address the lack of occupational health coverage within the basic curriculum and further training. However, the majority of GPs and practice nurses participating in the focus groups felt that substantial further training is not the solution. Occupational health is regarded as a specialism in itself, and they want experts they can refer to rather than becoming experts themselves. This may be a contributory factor in the low uptake of an occupational health 'distance learning' package for GPs and other primary health care staff (Centre for Health Policy and Practice, 2000).

#### **3.2.5.2 Resources**

Time constraints were identified as a limiting factor on GPs and practice nurses' ability to explore problems with patients, seek out information and follow them up. It was suggested that simple information on appropriate referral routes supported by quick and easy access would help in addressing occupational health problems for patients. Limited time and financial resources in primary care were felt to be subject to some unreasonable occupational health demands, specifically, organisations referring staff for Hepatitis-B immunisations and not accepting sickness certification for less than seven days absence.

The length of time patients have to wait for secondary care appointments was also felt to be a significant issue affecting the extent to which occupational health problems can be addressed for primary care patients. This is particularly pertinent to services for musculoskeletal disorders and mental health problems. Practice managers raised the issue of the need for funding to be made available to practices to support the provision of services such as counselling, physiotherapy, and occupational health advisors.

#### **3.2.5.3 Conflict of interest**

The various stakeholders raised the issue of patient confidentiality and a perceived conflict of interest between primary care and employers' occupational health provision as a potential barrier to effectively addressing occupational health problems for patients. This concern appears to be reinforced and the difficulties in addressing occupational health for patients compounded when they encounter patients who are afraid to involve their employers' occupational health service.

### **3.2.6 Local occupational health provision**

Knowledge of the Sheffield Occupational Advisory Service (SOHAS) among the Sheffield stakeholders appeared to be quite limited. Persons from practices that either previously had or currently have an SOHAS advisor available at their practices seemed to regard it as a useful service. Manchester stakeholders suggested a service not dissimilar to that currently provided by SOHAS would be useful.

### **3.2.7 Occupational health provision for primary care staff**

There was a perception that there had been some improvement in occupational health provision for staff, along with increased attention to health and safety in primary care. It was also evident that there are variable levels of awareness concerning the availability of occupational health

provision. In Manchester, occupational health provision was felt to be difficult to access due to its location. There is a desire for local and accessible provision but this needs to ensure privacy and confidentiality, particularly in relation to mental health services.

### 3.3 QUESTIONNAIRE RESULTS

Of 1000 questionnaires sent to a random sample of GPs 295 were completed and returned by June 24 2003 (a response rate of approximately 30%). The main points of the questionnaire are listed according to each section but the full results of the questionnaire can be found in Appendix 7.

#### 3.3.1 Demographics

The respondents had worked in General Practice for a mean of 16 years (range from 2 years to 40 years) and had a mean of 4 partners in each practice (range from working on their own to 13 other partners). 43% (124/291) were female and 57% (167/291) were male.

#### 3.3.2 Occupational health qualifications and information

The respondents were asked whether they had any occupational health qualifications or memberships and if not, were they pursuing this. Additionally they were asked where they obtained information on occupational health (from colleagues, on the job, training or publications).

- Of the respondents only 4% (13/295) had any occupational health qualifications or memberships, which ranged from a certificate in Occupational Health to an Associate fellow of Occupational Medicine qualification.
- Of those with no qualifications, 2% (5/277) were either pursuing an occupational health qualification or membership.
- We asked where individuals obtained information on occupational health (colleagues, on the job, training or publications) and most (73.4% 215/293) obtained occupational health information on the job, however there was an equal split between those who received information from colleagues (50% 147/293) and those who did not (50% 146/293)

**Key finding:** Less than 5% of GP's have any formal occupational health qualifications and only 2% were currently pursuing professional training in this area. 75% of the GP's questioned learnt about occupational health issues through their work and work colleagues.

#### 3.3.3 Patient consultations

Two questions were asked about whether the patient's occupation was addressed in the consultation, and whether this was recorded in the patient's medical records.

- 75% (219/294) responded that they often asked about the patients occupation, and of these, 81% (174/214) responded that they recorded the patients occupation in their medical records.
- In total, 79% (228/288) of respondents replied that they recorded the patients occupation in their medical records.

**Key finding:** 75% of GP's said that they enquired about the patients occupation during the consultation, and 80% of these said they would record this information in the patients records.

### 3.3.4 Frequency of occupational health problems encountered

Two questions asked about how frequently occupational health problems were encountered in consultations, and whether there had been any change in frequency in the last 18 months.

- The main health problems encountered at least once a week were musculoskeletal (50% of respondents 145/293) and mental health problems (48% of respondents 140/291).

We also split the respondents into two groups. Group 1 was those who 'rarely' or 'occasionally' asked about a patients occupation in consultations, and group 2 those who 'often' or 'always' asked.

- Individuals who 'often' or 'always' asked about occupation, were twice as likely (odds ratio = 2.11 [confidence interval 1.27-3.93]) to see patients with mental health once a fortnight or more, than those who 'rarely' or 'occasionally' asked.
- Over 70% of respondents saw no change in the frequency of which they encountered occupational musculoskeletal, skin health, respiratory, hearing, and visual problems and vaccinations. However it is interesting to observe that over half the respondents (58% 169/292) saw an increase in work related mental health problems.

**Key finding:** 50% of GP's reported musculoskeletal damage and mental health as the most commonly encountered occupational health complaints. More than half of the GP's reported that worked related mental health problems were on the increase.

### 3.3.5 Barriers to addressing occupational health problems

The main barriers to addressing occupational health problems were;

- Waiting times for specialist services (67% 193/289)
- Consultation times (63% 181/289)
- Lack of training (60% 172/289)
- Lack of referral routes (57% 166/289)
- Conflict of interest (21% 60/289) and confidentiality (17% 49/289) did not pose as a barrier to addressing occupational health problems for most GPs surveyed, however those individuals who recorded the patients occupation in their medical records were twice as likely (odds ratio 2.62 [confidence interval 1.07-6.45]) to consider 'conflict of interest' as a barrier to addressing occupational health problems.
- Individuals who had worked for more than 16 years, were less likely to perceive training (odds ratio = 0.49 [confidence interval 0.30-0.79]) or conflict of interest (odds ratio = 0.46 [confidence interval 0.26-0.82]) as a barrier than those who had worked for less time.

- Individuals who ‘often’ or ‘always asked about occupation, were twice as likely (odds ratio = 2.13 [confidence interval 1.16-3.93]) to perceive ‘lack of referral routes’ as a barrier than those who ‘rarely’ or ‘occasionally’ asked.

**Key findings:** Approximately 60% of GP's reported the following factors as obstacles to improved use of occupational health care; constraints on consultation time; lack of professional training; and lack of referral routes.

### 3.3.6 What would help to address patients occupational health problems?

Respondents replied that;

- Speedier access to secondary care (74% 213/289)
- Increased referral routes (66% 192/290)
- Training (62% 180/290)
- Information sheets (58% 167/290)
- Longer appointment times (53% 152/289)

would help to address patients occupational health problems.

- Individuals, who had worked for more than 16 years, were less likely to perceive that ‘training’ (odds ratio = 0.49 [confidence interval 0.30-0.80]) would help address patients occupational health problems than those who had worked for less time.
- Individuals who ‘often’ or ‘always asked about occupation, were twice as likely (odds ratio = 2.66 [confidence interval 1.45-4.88]) to perceive that ‘increased referral routes’ would help address occupational health than those who ‘rarely’ or ‘occasionally’ asked.
- Interestingly, female GPs were more likely to find information sheets useful than men (odds ratio = 1.63 [confidence interval 1.00-2.63])

**Key findings:** More than 50% of the respondents identified the following ways to improve the delivery of occupational health through primary care; speedier access to specialist care; increased routes of referral; improved training for professionals; better access to information; and longer patient consultation times.

### 3.3.7 Referral of patients

The questionnaire asked GPs which services (specialist primary care services, specialist secondary care services or occupational health services) they used for referral of patients with either work related musculoskeletal, skin, respiratory, hearing, mental health or visual eye problems.

- The majority of respondents replied that they used specialist secondary care services for the referral of patients, but not specialist primary care services or occupational health services.

### **3.3.8 Occupational health for patients in primary care**

GPs were presented with a series of statements, and asked whether they agreed or disagreed with them, or were unsure of their response. The main points are summarised below, and the full results can be found in section 10.7 (Appendix 7)

#### ***Resources and professional competency***

- Most of the respondents (82.9%) agreed (or strongly agreed) that GPs should be concerned with addressing occupational causes of ill health.
- There was roughly an even split between those respondents that did not have time to explore occupational health issues in patients consultations (strongly agree 6.2% and agree 35.1%), as those that did have time (44.3% disagree and 2.4% strongly disagree).
- Approximately 50% (4.1% strongly agree and 44.2% agree) of respondents felt competent to explore occupational health problems in patients, whereas 34.2% were unsure, and 17.5% felt that they were not (1.4% strongly disagree and 16.1% disagree)
- Over three quarters of respondents (12.3% strongly agreed and 71.3% agreed) felt that further training would improve their ability to address patients' occupational health issues.

#### ***MED 3 sickness form and fitness for work***

- Over two thirds of respondents (51.4% disagree and 16.1% strongly disagree) thought that the MED 3 sickness certification was not a useful tool for communicating with patient employers.
- Nearly half of the respondents (34.9% disagree and 12.3% strongly disagree) thought that the MED 3 should not be provided by the GP, whereas approximately a third (29.1% agree and 1% strongly agree) thought that the MED 3 should be provided by the GP.
- Approximately a third of respondents were unsure whether occupational health physicians were more concerned with reducing absenteeism than with what is best for individuals, however over 40% disagreed with this.
- The majority of respondents agreed (13.4% strongly agreed, 45.9% agreed) that doctor patient confidentiality prevents GPs communicating with the employer of patients.
- There was a roughly equal split between those respondents who thought that they did not have sufficient knowledge to assess fitness to work (8.2% strongly agree, 36.6% agree) and those who thought that they did (2.7% strongly disagree, 30.5% disagree).
- The majority (9.6% strongly agree, 60.8% agree) of respondents rely on the patients judgement regarding 'fitness to work'.

#### ***Obstacles to progress***

- The majority (36.4% strongly agree, 52.4% agree) of respondents agree that long waiting lists for secondary referrals prevent patients from returning to work earlier.

- The majority (36.5% strongly agree, 47.1% agree) of respondents agree that their workload has been increased by employers not accepting self certification.
- The majority (7.2% strongly agree, 51.9% agree) of respondents agree that GPs can only advise patients to speak to their employers about work related health problems.
- The majority (7.2% strongly agree, 48.5% agree) of respondents are not aware of services to refer patients to for occupational health problems.
- There was a roughly equal split between those respondents who are not aware of local occupational health provision for GPs (11.6% strongly agree, 35.8% agree) and those who are (8.2% strongly disagree, 34.1% disagree).
- Approximately half of the respondents (11.0% strongly disagree, 37.5% disagree) thought that occupational health provision for GPs in their practice has not improved in the past five years.
- The majority (27.1% strongly agree, 50.7% agree) of respondents feel that there is a need for improved occupational health provision for GPs.

**Key findings:**

- More than 80% of the GP's considered that occupational health was an important problem but lacked time for consultation.
- Lack of competency in occupational health was considered an obstacle by approximately half of the respondents.
- More than 75% of respondents agreed that further training would improve the delivery of occupational health.
- Most GPs questioned their role in certification of the MED 3 form and their effectiveness at judging fitness to work.
- Most GP's considered that doctor patient confidentiality may constrain communication with the employer
- Most GP's agreed that the provision of occupational health services, and awareness of these services, needed to be improved

## 4 DISCUSSION

### 4.1 **WHY DO GPs AND PRACTICE NURSES NOT TAKE GREATER ACCOUNT OF OCCUPATIONAL ISSUES IN THEIR DAY TO DAY CONTACT WITH PATIENTS OF WORKING AGE?**

- The principal reasons for the low priority attached to occupational health, centres on the lack of time within the framework of general practice to focus on these issues
- Evidence was seen of a lack of knowledge of occupational health issues and the perception that this is a specialist area that falls outside the remit of the general practitioner.
- The low priority given to occupational health issues during medical training was also regarded as a contributing factor.
- The results of the questionnaire survey revealed that a large majority of GPs routinely recorded the patients occupation on their medical records. Most GPs were concerned to address occupational causes of ill health. The focus groups discussions also highlighted the responsibility of the employer for the employees occupational health.
- Although most of the GPs said they routinely recorded the patient's occupation it not usually recorded formally on information systems in a standardised way (in contrast to other routine collected data e.g., smoking status). The literature review revealed that GPs lacked 'detailed knowledge' of the patient's occupation. For example, they may simply record 'engineer' without further detail of the nature of the work undertaken.
- The lack of education regarding occupational health was thought to be a problem by 60% of questionnaire respondents. However, focus group participants were not anxious to have more education. Rather, they felt that there should be a specialised service to which they could refer patients. Reasons for this preference included limited time within the consultation and limited access to counselling and physiotherapy services.
- Long waiting times for referral to specialist services was additionally identified as an issue, and it was thought that speedier access to secondary care would help address occupational health issues.
- Knowledge of Occupational Health Advisory Services was limited, however practices with this service felt it was useful.

### 4.2 **WHY HAVE PATIENTS' OCCUPATIONAL HEALTH ISSUES FAILED TO GAIN A HIGHER PRIORITY AMONGST PRIMARY CARE MANAGERS AND PLANNERS?**

- There seems to be a lack of clarity about the respective roles of employer's occupational health services and the primary care services. It was generally agreed that primary care has a role in addressing occupational health but this role is limited role and the employers need to take more responsibility. There also needs to be increased State

provision for occupational health for those patients who did not have access to these services through their employer.

- Lack of resources within primary care and poor communication with employers were also factors influencing decisions made by primary care managers and planners.
- Delays in referral to the appropriate secondary care professionals was perceived as a real problem, especially with regard to mental health and musculoskeletal problems, which were the most commonly encountered work-related problems in general practice.

#### **4.3 WHAT ARE THE PROFESSIONAL, SOCIAL, AND ECONOMIC PRESSURES THAT GIVE OCCUPATIONAL HEALTH A LOW PRIORITY?**

- Professional pressures include poor definition of roles and responsibilities with respect to occupational health within primary care.
- There was an ethical dilemma perceived by the healthcare professionals regarding communication with the employer when it was clear that the illness had an occupational cause. This issue is particularly relevant to the area of sickness certification and ‘fitness to work’.
- Economic pressures include the lack of time and resources available to general practice to address occupational health issues. This also applied to the absence of specific financial encouragement for occupational health activities.

#### **4.4 WHAT COULD HSE DO TO TURN THESE PRESSURES AROUND SO THAT OCCUPATIONAL HEALTH RECEIVES A HIGHER PRIORITY AND GREATER ACCOUNT IS TAKEN OF THE IMPACT OF WORK ON HEALTH TO THE BENEFIT OF PRIMARY CARE PATIENTS, WORKERS AND EMPLOYERS?**

The recommendations for actions by HSE fell into two categories, the first can be described as short-term practical initiatives, the second as campaigning issues that would require HSE to act as an advocate together with other government agencies

##### ***Short term initiatives***

- Improvements to the recording of occupational details in general practice will help to address this issue. Additional detail about the type of work and potential occupational health risks will aid decision-making by healthcare professionals.
- To work with NHS and other government departments to promote greater emphasis on occupational health in undergraduate and post graduate training for doctors and nurses as well as through continuing professional development.

- To develop better information resources (documents and Web resources) on occupational health suited to the needs of primary care. These would provide information on referral routes, access to occupational health provision/services (e.g., EMAS, SOHAS and DWP Disability Services).
- Simple screening questionnaires could be developed to highlight work-related ill-health of patients prior to their appointment with the GP.
- Promote professional development through increased awareness of occupational health issues using for e.g., Protected Learning Initiative (PLI) scheme, and approved occupational health study sessions.

### *Campaigning initiatives*

- To provide easier access to occupational health care services especially for work-related mental health and musculoskeletal problems that are commonly encountered in general practice.
- To see an increased provision for additional services within primary care particularly counselling and physiotherapy.
- Primary Care Trust (PCT) led occupational health services should be developed and made available to all practices within the trust.
- Clarify the roles and responsibilities of the primary healthcare teams, occupational health care providers, and employers with respect to occupational health needs of the employee.
- To change the perception that occupational health is not a key issue for funding within PCT's.

## **4.5 RECOMMENDATIONS**

In considering the results and conclusions of this study it was clear that there were two types of recommendations for actions that could be made. The first could be described as practical objectives for changes that in the short term could deliver progress. The second set of issues related to more significant issues that would require development across many government agencies and national bodies who approve curriculum for medical education and professional development. The list of recommendation below cover those issues for which HSE can more directly influence change, commission research, and support models of good practise. The longer term 'campaigning' goals are identified in the conclusions section to the report. These recommendations reflect a number of the initiatives that were highlighted in the review of the literature (Appendix 4).

- 1) The results of this survey suggest that practice nurses and practice managers are best placed to respond to the occupational health agenda if given the appropriate support and resources. Consequently further work should be undertaken to identify the needs and obstacles for these groups in delivering services to patients with occupational health needs.

- 2) Primary health care staff need improved access to information and specialist occupational health advice. In the long term changes to the medical curriculum are required but in the short term consideration should be given to supporting:
- Better information on routes for referral and access to specialist occupational health services
  - Development of simple screening questionnaires to highlight those patients with work-related ill-health.
  - To examine practical ways to record the patients occupational health history within the existing structures for recording a patients medical history
  - On-line resources for occupational health routed through the existing major providers to primary health care staff.
    - Resources to support continuing professional development in partnership with the NHS, DWP and other government departments
    - Resources to support continuing professional development in partnership with the NHS, DWP and other government departments

## 5 APPENDIX 1: FOCUS GROUP TOPICS

### Patient's occupational health in Primary Care: Focus Group Topics

1. What is your understanding of occupational health provision for patients in primary care?

Prompt

- What do you regard as occupational health issues?
- What do you regard as occupational health provision?
- Who in primary care is involved?
- Who is affected by occupational health provision in primary care?

2. Should occupational health be addressed in primary care?

Prompt

- Who should be involved?
- How?
- Why?
- If NOT primary care, where should occupational health issues be addressed?

3. What have you (your practice) done to address occupational health issues? (elicit examples)

Prompt

- How?
- What prompted this action?
- What facilitated/helped?
- What barriers/difficulties did you encounter? (e.g., knowledge; information; advice; skills, training; support services; referral sources; time; resources; ethical issues)
- How were barriers/difficulties overcome?
- What else would have helped?

4. If you were faced with an occupational health issue, what would you do

Prompt

- Where would you go?

5. What obstacles make it difficult to address occupational health in primary care?

6. Where have you learned about occupational health issues? (e.g., education; training, information sources; networks)

Prompt

- How has this helped in addressing occupational health issues for patients? (elicit examples)

7. What else would help in addressing occupational health issues? (e.g. knowledge; information; advice; skills, training; support services; referral sources; time; resources; ethical issues)

8. How is information relevant to occupational health gathered?

Prompt

- How is this information managed/used?
- How could this be improved?

9. Does Sickness Certification (Med 3) have any impact on how occupational health issues are addressed?

Prompt

- Has it ever lead to any intervention?
- How is the 'comments' section used?

10. What occupational health provision is available for staff in primary care?

Prompt

- Knowledge of provision?
- Use of service?

## 6 APPENDIX 2: GP SURVEY QUESTIONNAIRE



### OCCUPATIONAL HEALTH IN PRIMARY CARE GP SURVEY

#### What is this questionnaire about?

- This questionnaire asks for your views on the role of General Practitioners in addressing occupational (work related) health issues for patients in primary care. It also includes some questions on occupational health provision for GPs.
- Most of the questions require you to either tick a box or circle a chosen response.
- It should you take about 5 minutes to complete.

#### Who will see my answers?

- The questionnaire is anonymous. No individuals can be identified in connection with any of the results.

#### How do I return the completed questionnaire

- The completed questionnaire can be returned in the enclosed pre-paid envelope.
- Please return by \_\_\_\_\_

Q1. What year did you qualify as a General Practitioner? \_\_\_\_\_

Q2. How long have you worked in General Practice? \_\_\_\_\_

Q3. How many partners are there in your practice? \_\_\_\_\_

Q4. Do you have any Occupational Health qualification or membership? No  Yes

If 'Yes' give details: \_\_\_\_\_

Q5. Are you pursuing any Occupational Health qualification or membership? No  Yes

If 'Yes' give details: \_\_\_\_\_

Q6. How often do you ask about a patient's occupation in consultations? (*tick one box*)

Rarely  Occasionally  Often  Always

Q7. Do you record patients' occupation in your medical records? No  Yes

Q8. Where have you obtained information on Occupational Health? (*tick all that apply*)

Colleagues   
On the job   
Training (give details)  \_\_\_\_\_  
Publications (give details)  \_\_\_\_\_  
Other (give details)  \_\_\_\_\_

Q9. Are you: Male  Female

Q10. To what extent do you encounter the following occupational (work related) health problems in patient consultations: (*tick one box per line*)

	<i>Less than once a month</i>	<i>Once a month</i>	<i>Once a fortnight</i>	<i>Once a week</i>	<i>Daily</i>
a. Musculoskeletal (e.g. back pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin (e.g. dermatitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Respiratory (e.g. asthma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental health (e.g. stress)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Visual/Eyes (e.g. eyestrain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Vaccinations (e.g. HepB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q11. Have you noticed any change in the last 18 months in the extent to which you encounter each of these **occupational health problems** in patient consultations: *(tick one box per line)*

a. Musculoskeletal	Increase	[ ]	No change	[ ]	Decrease	[ ]
b. Skin	Increase	[ ]	No change	[ ]	Decrease	[ ]
c. Respiratory	Increase	[ ]	No change	[ ]	Decrease	[ ]
d. Hearing	Increase	[ ]	No change	[ ]	Decrease	[ ]
e. Mental health	Increase	[ ]	No change	[ ]	Decrease	[ ]
f. Visual/Eyes	Increase	[ ]	No change	[ ]	Decrease	[ ]
g. Vaccinations	Increase	[ ]	No change	[ ]	Decrease	[ ]
h. Other (specify) _____	Increase	[ ]	No change	[ ]	Decrease	[ ]

Q12. What local services do you use for referral of patients with the following **occupational health problems**? *(tick all that apply)*

	Specialist Primary Care	Specialist Secondary Care	Occupational Health Services	Other (give details)
a. Musculoskeletal	[ ]	[ ]	[ ]	_____
b. Skin	[ ]	[ ]	[ ]	_____
c. Respiratory	[ ]	[ ]	[ ]	_____
d. Hearing	[ ]	[ ]	[ ]	_____
e. Mental health	[ ]	[ ]	[ ]	_____
f. Visual/Eyes	[ ]	[ ]	[ ]	_____

Q13. To what extent do the following make it difficult for you to address patients' occupational health problems? *(tick all that apply)*

Lack of training	[ ]
Consultation times	[ ]
Lack of referral routes	[ ]
Waiting times for specialist services	[ ]
Conflict of interest	[ ]
Confidentiality	[ ]
Other (give details)	[ ] _____

Q14. To what extent would the following help you to address patients' occupational health problems? *(tick all that apply)*

Training	[ ]
Longer patient appointment times	[ ]
Information sheets/leaflets	[ ]
Increased referral routes	[ ]
Speedier access to secondary care	[ ]
Other (give details)	[ ] _____

Q15. Please indicate to what extent you agree or disagree with the following statements about occupational health for patients in primary care. (circle one statement per line)

a. GP should be concerned with addressing occupational causes of ill-health	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
b. I do not have time to explore occupational health issues in patient consultations	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
c. I feel competent to explore possible occupational health problems in patients	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
d. Further training would improve my ability to address occupational health issues for patients	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
e. MED 3 sickness certification is a useful tool for communicating with patients' employers	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
f. MED 3 sickness certification should continue to be provided by GPs	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
g. Occupational health physicians are more concerned with reducing absenteeism than what is best for individuals	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
h. Doctor-patient confidentiality prevents GPs communicating with the employer of patients	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
i. I do not have sufficient knowledge to assess 'fitness to work'	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
j. I tend to rely on the patients judgment regarding 'fitness to work'	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
k. Long waiting lists for secondary referrals prevent patients from returning to work earlier	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
l. My workload has been increased by employers not accepting self certification	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
m. GPs can only advise patients to speak to their employers about work related health problems	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
n. I am not aware of services to refer patients with occupational health problems	Strongly agree	Agree	Unsure	Disagree	Strongly disagree

Q16. Please indicate to what extent you agree or disagree with the following statements about occupational health provision for GPs. (circle one statement per line)

a. I am not aware of any local occupational health provision for GPs	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
b. Occupational health provision for GPs in my practice has improved in the past five years	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
c. There is a need for improved occupational health provision for GPs	Strongly agree	Agree	Unsure	Disagree	Strongly disagree

Comments: Thank you for completing this questionnaire; if you have any additional comments please write them here.

## 7 APPENDIX 3: GP SURVEY LETTER

Broad Lane, Sheffield, S3 7HQ  
Telephone: 0114 2892000  
Facsimile: 0114 2892500



**Please can you help the Health & Safety Executive to understand  
Occupational Health Issues in the Primary Care Setting.**

We have been contracted by the UK Health and Safety Executive (HSE) to collect information about your perceptions of occupational health issues when dealing with patients. This work will help to develop new policies to try and prevent occupational ill health. To help us with this task, we would be very grateful if you could complete the enclosed questionnaire; this has been developed following a number of meetings with practicing GPs, practice nurses and practice managers.

This study is being conducted in collaboration with the General Practice Research Unit, South Manchester University Hospitals NHS Trust

The information you provide will help HSE to identify barriers you face in the effective delivery of occupational health support and advice to your patients.

Yours faithfully,

Dr Andrew Curran  
Head, Biomedical Sciences Group

Enc.

An Agency of the Health and Safety Executive

## **8 APPENDIX 4: LITERATURE REVIEW**

Illness resulting from a patient's work, and the impact of ill-health on a patient's capacity for work, are important issues for primary health care. The potential of primary care (as a setting for intervention) to improve the health of the workforce has been evident for many years (Vaughan, 1960) in both industrialised countries and transitional economies (Kocks and Ross 1995).

Research over the past twenty years has shown that work plays a major role in the health of adults, both as a cause of ill health (Harber 1994 D'Auria 1989) and also as a potential health promoting activity. Additionally there is also a renewed interest in maintaining the working capacity of employees to increase productivity and reduce business costs. Information regarding the influence that work can play on the health of adults has increased interest in the role that primary health care could play in illness prevention (CEC). Recently the Health and Safety Commission in conjunction with other Government bodies produced an occupational health strategy 'Securing Health Together'. Information contained within this strategy includes specific recommendations for measures at primary health care level to contribute to the common goal of reducing work-related ill-health and sickness absence (OHAC, 1999).

From the literature it is suggested that primary health care generally lacks (with a few exceptions) a systematic role in the prevention of ill-health or in the rehabilitation of adults back to work even in developed countries (Rasanen 1993). Published reports emphasise that primary health care professionals face many difficulties in realising this potential for addressing work-related health issues. This review will examine the obstacles that have been identified by the authors of the few well-documented reports on this subject, and will also examine the solutions that have been proposed or adopted to overcome these problems. The review will highlight the proposals (or examples) that demonstrate most promise to address this issue, and also identify outstanding problems still to be resolved. Yassi (1990) has pointed out that given the current provision of occupational health services in the workplace, primary health care is the only means by which most of the workforce will receive occupational health support. The problem of how best to deliver this objective has still to be addressed.

### **8.1 OBSTACLES TO PROGRESS**

The scientific literature is concentrated on two kinds of obstacle to effective intervention in the delivery of occupational health care by primary health care services. The first kind concerns the structure of primary health care, the second the process of delivery. Structural problems concern the staff available to carry out the work; GPs, nurses, physiotherapists, counsellors and others; their training, knowledge and the resources available to them. The second set of obstacles relate to the process by which primary health care and the world of work become engaged with one another. Obstacles of this kind include communications problems, real or imagined conflicts of interest between agencies, and ethical dilemmas.

### **8.2 KNOWLEDGE AND TRAINING**

General practitioners often lack detailed knowledge of their patients' work (Gerrard 1998), because of the complexity of the workplace; work tasks, and working environment and the employment history of many individuals (D'Auria 1989, Dickenson 1985). Furthermore the knowledge that GPs have of the impact of illness upon the ability to work also appears limited (Memel 2000).

Accessing appropriate services through the primary health system is also difficult as GPs often lack knowledge about the availability of specialist services. Blaxter (1980) and more recently

Sawney (2002) draw attention to the need for improved knowledge of rehabilitation services amongst primary health care teams. Additionally Sen (1997) and Osborne (1997) draw attention to the crucial role that primary health care could play in directing patients towards welfare benefits for occupational disease sufferers and also point out the apparent lack of knowledge of these support mechanisms.

Given this lack of knowledge concerning factors that are of direct benefit to the patient, it is not surprising that the value of collecting occupational illness data using national databases is not well understood. GPs in UK (Sen and Osborne 1997) and US (Blanc 1989) lack knowledge about the systems for recording and reporting work-related illness, and in the UK many seem unaware of the rules for reporting work-related deaths to the coroner (Start 1995). GPs (Wood 1985) and practice nurses (Rivett 1992) often do not have practice based resources to utilise in these circumstances, and Seaton (1995) has suggested that the decline in strength of the Employment Medical Advisory Service as a source of advice for primary health care practitioners has made this shortage of expertise even more serious.

It is apparent that some GPs know more about occupational health than others, for example those individuals who take up posts as occupational health specialists with local enterprises (Semence 1984). This difference has also been highlighted in an unusual study of US doctors (Sokas 1997). This paper examined doctors at various stages in their training and proposed that students appeared to know more than qualified clinicians, and that doctors from working class backgrounds knew more about occupational health issues than those who were from more privileged backgrounds.

The coverage of occupational health issues in the training received by primary health care staff has received much attention. Typically basic medical and nursing curriculum contain very little content on occupational health (Seaton 1995, Griffin 1992). As little as a few hours may be devoted to this subject in a 5 to 6 year pre-clinical and clinical training period. Additionally, occupational medicine is usually excluded as a subject from general medical textbooks (Felton 1980). The omission of occupational health from the pre-registration training could be remedied at a later stage. All GPs in training take part in vocational training schemes before they can practice as GP principals. However, in a UK survey, the majority of vocational training schemes do not deal with work related health issues (Parker 1996). Continuing medical education (CME), a requirement for all primary health care staff, often lacks a systematic basis and few GPs choose occupational medicine as an option for their CME

### **8.3 PROCESSES**

Several different sets of interests are involved in the decisions primary health care professionals make about a patient's ability to work.

- GPs will advise the patient to refrain from or return to work as part of the clinical management of a specific health problem. A GP will also foresee the health consequences of job loss and the financial risk for patients who may lose benefit entitlement if they are deemed fit to work but are unable to find a job.
- The State, which has overall responsibility for increasing social cohesion and controlling the costs of social security provision, has identified sickness certification as a key intervention by which the GP contributes to these health objectives (Sawney 2002).
- Patients have a variety of concerns that often, but not always, coincide with those of the GP (they may wish to return to work when the GP feels this is inadvisable, and conversely may wish to stay away from work when a GP sees no reason for this).

- The employers interests vis-à-vis the employee's health, are focussed on the issue of minimising lost working time and in keeping trained staff. When it clear that the employee is less likely to return to work and unable to fulfil their part of the employment contract, the issue of discontinuing their employment is raised.

Marrying these complementary or conflicting interests is complex. GPs receive little if any formal training in dealing with them (Toon 1992, Sawney 2002). The lack of relevant knowledge has been described above, but there are also concerns that there are ethical conflicts that cannot be resolved to the satisfaction of all parties (Toon 1992, Rosenstock 1987). This can certainly be the case where a patient's GP also acts as their occupational physician Hainer 1981, Dickenson 1985).

GPs and occupational physicians frequently express doubt about the objectivity of each others decisions regarding patients (Morgan 1999). GPs are concerned about the confidentiality of information they provide to employers concerning the patient's health (Adishes 1996), and about their lack of knowledge of the work the patient performs (De Buck 2002). Sawney (2002) has expressed the concern that some patients are more aware of their right to social security than of their responsibility to participate in society through work. The GP therefore, could be in a position to change the balance of these perceptions concerning rights and responsibilities. The patient perspective on the role of GPs in educating about workplace health appears not to have been reported. However patients' interests are protected by legal provisions under the Access to Medical Reports Act and the Data Protection Act that controls the information that can be divulged by a patient's GP to the employer.

A number of papers have attempted to analyse how far these perceived conflicts were supported by survey data. De Bono (1997), in an audit of referrals to a hospital occupational health department, found that GPs contributed new information in 46% of communications with occupational physicians, and that occupational physicians and GPs changed their actions as a result of these communications. De Buck (2002), in the slightly different context of the Dutch occupational health system, found dissatisfaction on both sides about the quality of communication and argued that the GPs' lack of knowledge of occupational health was the main obstacle to an improvement. Faber (2002) additionally confirmed the lack of trust between occupational physicians and general practitioners but found that generally occupational physicians valued their relationships with GPs more than GPs valued their relationship to the occupational physician.

Adishes (1996) and Parker (1996) suggested that the GPs' anxiety about the confidentiality of health information supplied to the workplace is misplaced. However other reports on the pressures experienced by occupational health professionals in the workplace imply that this is not always the case (Ballard 2002). Noting the GPs view that many occupational physicians involved themselves unnecessarily in the employees' primary health care, Parker (1996) found that only 21% of GPs in his sample felt occupational health services 'always acted in the best interest of their employees'.

#### **8.4 OVERCOMING THE OBSTACLES**

There is no shortage of suggestions regarding how to overcome the many obstacles to an effective (synergistic) relationship between the workplace and primary health care. The very persistence of these obstacles over many decades, economies, and cultures, suggest that effective solutions will need to address deep-seated problems.

### 8.4.1 Training

The existing pre-registration training of GPs and nurses (Griffin 1992) is already so intensive that the inclusion of additional material on occupational health is unlikely. A variety of authors have looked for a solution in the development of new kinds of medical curriculum based on the needs of communities (D'Auria 1989, Fried 1987) or in problem-based learning. The value of the latter approach draws support from research into the factors associated with insight into a patient's work. Yassi (1990) has demonstrated methods to assess medical students' skills at identifying occupational ill-health using a standardised group of patients; and found that the medical students with most success were those with the most highly developed interpersonal skills.

In the training of GPs, Parker (1996) found willingness on the part of vocational training schemes to provide training on occupational health, if it could be made easier for them to do so. Training materials of the kind required have been developed in the past (Marcus and Lee 1980), though the more recent survey suggests that the utilisation of such materials is poor. A 'distance learning' package has also been developed for use by GPs and other primary health care staff with funding from relevant government departments but again, uptake has been slow (Centre for Health Policy and Practice, 2000).

An underlying problem is the failure to clearly define the core skills and knowledge that should be fitted into the training received by medical students, GP registrars and practising GPs, and by other health professionals. There is agreement that an ability to take an occupational history is a basic skill, and that information on the resources and systems available to patients and clinicians should be absorbed. Sawney (2002) (Appendix 5) describes the skills needed by GPs to make decisions on work-related issues, sickness certification and vocational rehabilitation. An understanding of the financial implications of these consequences and of the options for patients should also be included. The list is so long that it immediately raises fear that no imaginable training – whether problem-based or traditional in structure - could provide time to master all the necessary components.

Many authors have identified that a lack of knowledge concerning the local workplace and the patient's occupational history is a limiting factor to progress. Visits to local workplaces have been recommended (Wood 1985) and are the most common way in which occupational health is dealt with in vocational training scheme teaching (Parker 1996). Recent research commissioned by the Health and Safety Executive lead to the development of a decision aid to assist GPs in the diagnosis of work-related upper limb disorders (Sinclair 2000, Graves 2000), an approach which recognises the problems GPs have with diagnosing commonly occurring occupational problems. An optimistic view is that changes to the structure of vocational training schemes will lead to a common curriculum that will include occupational health.

Others authors locate the solution to this problem in how the GP accesses information. GPs have in the past been found to make little use of the primary occupational health literature (Wood 1995). Updates must be delivered to them in a form that is easily absorbed (SOHAS 2003). Data systems built into general practice computer systems could make this information more readily available during consultations. Technical devices such as decision aids might also provide an answer to lack of relevant clinical knowledge.

In a perceptive article, Fried (1987) took a different view, suggesting that the problem with the occupational health literature is that it does not relate to the situation that primary health care professionals find themselves in. Many articles look at the health problems arising from particular kind of work, whereas what a primary health care professional wants to know, is whether a patient has a health problem that could have been caused by work.

## **8.5 OVERCOMING THE COMMUNICATION PROBLEM**

Ethical problems are commonplace in health care, where health professionals frequently face decisions regarding diagnosis, access to treatment and who else to inform about the diagnoses, and these conflicts relate to rights and duties. Introducing occupational health into primary care increases the range of interested parties, and of rights and duties, but it does not alter the nature of the decision making, most of which can be taken once issues are clarified by good communication. Changes to the organisation of occupational health in the Netherlands have prompted a series of studies into ways of improving relations between occupational physicians and primary care practitioners. Using techniques drawn from social psychology Faber (2002) and colleagues have devised ways of doing this. They have drawn occupational health practitioners and GPs into collaborations to agree and implement guidelines on the rehabilitation of workers with mental health problems and chronic back pain. Nauta (2002) found that well-planned contacts between the professions could increase the level of trust, though adherence to the guidelines has proved difficult for both professional groups. Other authors have suggested that more use of telephone conversations might improve relationships (Adisesh 1996), although there are concerns that access to medical reports and patient confidentiality cannot be adequately protected in such conversations. The Dutch approach however, appears to promise a more fundamental shift in the direction of clinical partnership.

Of course conflicts of interest and profound ethical dilemmas will still persist. However, the primary health care setting gives a clear lead as to how to resolve these dilemmas and is likely to be able to provide holistic occupational health care in the way envisaged by the ILO Convention and Recommendations on occupational health.

## **8.6 HARNESSING THE POTENTIAL OF PRIMARY CARE**

A number of ways of improving primary care systems have been explored. Simple screening questionnaires have been devised to enable patients to highlight their work-related health problems when they visit primary health care centres (Schwartz 1991, Wasem 2000, Isanedighi 1995). The use of community-based secondary referral centres has been studied (Koh 1994), and a number of primary care-based occupational health adviser projects in UK have reported on their activity (SOHAS 2000, 2001) and effectiveness (Agius 1989, Tilford 2001).

Enriching consultations in primary care with insight into a patient's occupational health care can achieve benefits for all. It can highlight workplace exposures and lead to prevention at work (Dobie 1987), improve the management of work-related disorders (De Bono 1997), and lead to more rapid reintegration of patients into work. Services providing integrated primary and occupational health care have shown benefits of these kinds (Tilford 2001, Agius 1989).

## **8.7 CONCLUSION**

The literature provides some information on the obstacles to improved occupational health provision within the primary care sector, but there is a shortage of reports on how to integrate these two disciplines. One interpretation of this situation is that there must be fundamental obstacles to the proposed integration. To understand what these difficulties are, it is worth reviewing the main function of primary health care. This is a system for managing health at the community level, referring patients to secondary or tertiary care when they require specialist services and treatment. In spite of this and many recent changes, primary care remains largely reactive and palliative.

To expect an additional service that can address the issue of preventing occupational ill health (within the context of the social benefits to the workforce) within existing budgets and many contending priorities is unrealistic. Several studies have identified time, staff, and support as the limiting factors for these initiatives (Sinclair 2000, Nauta 2002). To secure the resources needed the financial and ethical arguments raised against occupational health initiatives must be

addressed. Small additional resources for introducing occupational health into primary care (Gates 2000), or the provision of more occupational health specialists, may suffice (Rivett 1992, OHAC 1999) but the issue of a secure source of such funding is critical.

In Finland, the ethical basis for including comprehensive occupational health care within primary health has been accepted and implemented. However in most liberal economies, the financial case for demonstrating these benefits to the patient, employer, and for the social and health care system, has not been developed. Current developments in the UK and Netherlands (Sawney 2002, Department of Work and Pensions 2002, Weel 1999) should raise the profile of the ethical and social benefits outweighing the pre-eminence of short term financial measures. The financial case is always strongest for interventions that lead to benefits in the short-term, however too much concentration on short-term benefits will produce unbalanced solutions to this long-standing problem.

## **9 APPENDIX 5: CLINICAL KNOWLEDGE AND SKILLS RELEVANT TO SICKNESS CERTIFICATION (FROM SAWNEY, 2002)**

### **The nature of the patient's medical condition and how long the condition is expected to last**

- Skills as a diagnostician and in assessment of functional disability
- Skills in access data about appropriate periods of incapacity; for example for different medical conditions and surgical procedures
- Skills in referring for specialist advice

### **Functional limitations which result from the condition, particularly in relation to the tasks the patient performs at work**

- Skills in functional disability assessment
- Skills in taking an occupational history
- Knowledge of the workplace and relevant occupational health issues or ability to access appropriate sources of expert advice

### **Any reasonable adjustments that might enable the patient to continue working**

- An understanding of the needs of employers and employees
- Knowledge of relevant UK law such as the Disability Discrimination and Health and Safety at Work legislation and its related guidance

### **Appropriate clinical guidelines**

- Awareness of, and ability to apply, current evidence-based guidelines to clinical practice

### **Clinical management of the condition which is in the patient's best interest regarding work fitness**

- Skills in therapeutics and current best clinical practice
- Knowledge and understanding of local rehabilitation and employment related services
- Skills in enabling the patient to access appropriate services

### **Managing any conflict of interest between the GPs caring/advocacy role and the patient's need for economic support or compensation**

- Knowledge of the roles and responsibilities of the certifying doctor, the employer and the various other agencies involved
- Skills in negotiation and managing confrontation

### **Managing the patient's expectations in relation to his or her ability to continue working**

- Skills in couching clinical diagnoses in terms of physical, mental and social parameters
- Skills in clinical consultation and eliciting any 'hidden agendas'

## 10 APPENDIX 6: FOCUS GROUP RESULTS

### 10.1 GP FOCUS GROUPS: KEY FINDINGS

#### 10.1.1 Occupational Health problems

There was a marked consistency among GPs in relation to the types of occupational health problems encountered in patient consultations. The two major problems encountered are musculoskeletal disorders, in particular back problems, and mental health problems (stress and depression). Requests for Hepatitis B immunisations also represent a significant occupational health issue for primary care.

*We do a lot of HepB immunisations for people, that's actually an occupational health service we're providing isn't it, which should enable us to have some recognition...There seems to be more people who've been advised to have HepB these days, but there seems to be some kind of difficulty – people come in saying I've been to the occupational health department at work; I can't have my injection for six months so can you do it. (Sheffield GP)<sup>2</sup>*

Other work related conditions GPs encounter in patient consultations included respiratory/chest problems, dermatological/skin problems, and diarrhoea in food industry workers. Stress and musculoskeletal disorders were perceived as more difficult occupational health problems to address in terms of their diagnosis, identification of causes and treatment, than other problems (e.g. skin, respiratory). GPs also become involved in occupational health provision for patients when the occupational health departments of companies contact them for information on patients.

#### 10.1.2 Exploration of occupational health in consultations

GPs generally ask about occupation within patient consultations, although this information is not always recorded, and records are not always updated. An associated problem was identified in that it is difficult to keep up to date with changes in patients' job/occupation. It was suggested that they possibly explore occupational health problems to a greater extent than they actually realise, but not necessarily in a routine manner.

*I think we probably ask more about the job than we think we do. (Manchester GP)*

GPs exploration of occupational health is more focused when they feel it may be a relevant issue to consider for a patient. One of the participants stated that for them this did not take long to do.

*Certain diseases would trigger me to take more of an occupational history; with dermatitis obviously you're going to be interested in the sorts of chemicals they might be using. (Manchester GP)*

*You're dealing with people and trying to work out what's causing the problem for that person, who spends the majority of their weekly life at work so that's going to impinge on your history taking, and how you treat them, and how you're going to follow them up. (Manchester GP)*

*I'm conscious of the need to ask about jobs...but I'm not confident that I do that part well, patients do volunteer that they're having problems with their job. (Manchester GP)*

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<sup>2</sup> Quotes from focus group participants are presented in italics

### 10.1.3 MED3 Sickness certification

On the subject of GPs role in MED3 Sickness Certification, arguments were presented both in favour of and opposing this function. The negative aspects of sickness certification included the belief that it wastes GPs time in situations where patients are simply seeking ‘a piece of paper’ rather than the professional skills or knowledge of the GP. They were in agreement that a significant difficulty they face in completing sick notes is that on many occasions judgements regarding ‘fitness to work’ are very subjective, and they have to rely on what the patient says. This is particularly the case for problems such as back pain.

*If I get somebody with a bad back, one, they might not have a bad back at all and I can't tell, I've no idea how much pain they're getting from it; and two, I've no idea how its going to affect them at work, only they can tell me that. Most of the time I'm fairly relaxed about it and leave it up to the patient. (Sheffield GP)*

Some GPs felt that in certain instances occupational health professionals may be better placed to issue sick notes, as they would be more familiar with the actual demands of the person's job.

GPs also felt that their time was wasted on patients referred from hospitals for sick notes, as they believe hospital-based health professionals are more qualified to make judgements in relation to the problem concerned.

*We had two [patients] in yesterday, both had been in hospital; this is what drives me mad...I said why didn't the hospital do it [sick note] and he said oh they don't do it. That happens week in, week out. (Sheffield GP)*

Companies not accepting self certification was also highlighted as an additional demand on their time.

*Increasingly employers are asking people to come, as they won't accept a self-certificate. (Sheffield GP)*

*I'd like to see self-certification extended; it would cut our workload down...and then its up to the company to review them. (Sheffield GP)*

Individual GPs and practices employ various strategies for addressing this issue, including: providing the patient with a copy of guidance for employers on sickness certification, which explains that GPs are not obliged to provide sickness certificates for illnesses of seven days or less, and charging companies who are ‘frequent offenders’ for each certificate.

On a more positive note, arguments in favour of GPs involvement in sickness certification included the fact that patients have to come to the surgery and that the GP is made aware they are sick. In addition, it makes them discuss the patient's work and can provide an opportunity for contact with their employer. For example, one GP recommended alternative work hours on the sickness certificate.

*It encourages them to come to the surgery. (Sheffield GP)*

*Sometimes it's useful to get people to come and see you, people who wouldn't otherwise bother. (Sheffield GP)*

#### **10.1.4 Occupational health education and training**

On the subject of occupational health coverage in medical education/training, GPs were consistent in their response that they had very little specific occupational health coverage in their training and rely on their 'general' training and medical knowledge.

*We've got a lot of people that work in fairly heavy, manual jobs, we get a lot of bosses asking us when we think they'll be able to return to work, we just refer them all to their occupational health physicians 'cos we don't have any training in it, we're not qualified.* (Sheffield GP)

However, they did emphasise that they consider an all round level of knowledge is not possible, and that they need additional specialists in occupational health rather than occupational health training for GPs.

*Occupational health is proper speciality done well...we can never be a substitute for qualified occupational health physicians.* (Manchester GP)

*You're either a scientist or an applied scientist, a doctor or an applied doctor. We can't know about diabetes, heart problems, mental health and every other medical problem under the sun, the impact in relation to certain working condition. Someone else has got to be the expert with those fields.* (Manchester GP)

There was a general lack of support for additional training beyond the desire of specific individuals to pursue an interest in occupational health. A small number of participants in Sheffield and Manchester have pursued special interests in specific conditions or occupations.

On the whole GPs appear to want experts that they can refer patients to, rather than becoming experts themselves.

*Too broad an area to know everything, just got to know enough to pick up the trigger points, the red flags and know where to send patients.* (Sheffield GP)

*Even a set of guidelines on what is available locally.* (Sheffield GP)

*Everything else is getting frameworks, follow this flowchart, that kind of thing, whereas this is totally open, there's no guidance. I've never seen anything, even lectures, anything like that.* (Sheffield GP)

*The British Heart Foundation provide useful updates...one side of A4...most of it quite a simple level - not too high tech, they prompt you to remind you...they keep you up to date.* (Sheffield GP)

#### **10.1.5 Role of primary care in addressing occupational health problems**

On the issue of the role of primary care in addressing occupational health problems, it was felt that employers should fund occupational health services, not primary care or the NHS. An overall solution to addressing occupational health problems was felt to lie in the improvement of provision and access to occupational health resources for all workers, supported by an effective information system for all stakeholders (workers, employers and health professionals).

*We clearly have a role but I don't think the role can be tweaked here and improved a little bit there. In reality unless there's a major change in our function, role and resources then the answer has to be something along the lines of a compulsory occupational health service for all employees beyond a certain size of firm they've got to provide it, below a certain size is a sort of state run service.* (Manchester GP)

*At the moment they're all very keen for us to train in ENT and dermatology; – all we're doing there is seeing hospital patients there's nobody to see in hospital and it's the same problem with this. (Sheffield GP)*

*Look at the way primary care is going there's more and more nurse led care, nurse practitioners doing minor illness clinics - that's one answer. (Sheffield GP)*

*In our practice we have a lot of self employed people with small business, managers of small businesses, which have no occupational health department. In a way we have to be their surrogate occupational health advisers. They often work very long hours, neglect themselves in lots of ways. Its those people, I find there is no answer for (Manchester GP)*

Patient education in relation to the hazards posed by their job was considered to be important in making them more aware of potential occupational health problems.

#### **10.1.6 Barriers to addressing occupational health**

A number of difficulties affecting the extent to which GPs can address occupational health for patients in primary care were identified. Lack of knowledge in relation to what is actually happening in the patient's workplace and their actual job demands means that GPs have to rely on patient's accounts in considering 'fitness to work'.

*It's often a bit difficult if you don't know what people do at work to advise whether it's appropriate for them to go back. There was a particular person I was involved with who had a pin in his hip and back and he could drive certain kinds of vehicles but he couldn't climb up and down to secure loads. He had a lot of input from occupational health and the OT [occupational therapy] department and others. They couldn't agree so they asked me and I hadn't really much evidence to base a decisions on except what they [patient] told me. (Sheffield GP)*

*When you're doing letters to the company its difficult to know the exact detail of what the person does. (Manchester GP)*

This applies to 'simple' sickness certification and more detailed 'return to work' assessments. This can be particularly problematic where patients are pursuing compensation claims, which GPs stated could create additional work and mean that their opinion could be challenged. However, as noted above, GPs did not regard additional training as the solution.

*We get approached by companies for reports in relation to ability to work over and above simple sick notes that we provide. Often it's a situation where they are asking for a specialist opinion, which I as a GP don't feel I'm able to give nor do I feel I am the right person in other respects. Whilst you might say being an advocate should mean getting patients back to work, I also feel I have no training and support whatever they tell me. (Manchester GP)*

*Me saying you need this is not going to stand up in court, 'cos the lawyers just gonna say you don't have any occupational health training. (Sheffield GP)*

*Last night I spent an hour doing a medical report for a medical adviser who asked me about a patient with chronic back pain and a urinary tract infection. They wanted me to answer questions like: how valid is the illness; what type of modifications could be made to the workplace and the type of work; and a number of other questions that unless I was actually in the workplace I wouldn't know. It really struck me that here's a medical adviser, what are they doing asking me those questions. At the end of the day they're just abdicating responsibility for making decisions to somebody else. Short of saying I refuse to answer it, which might not be in my patients best interest. I was caught in an impossible situation. (Manchester GP)*

*In the past when I've had forms like that I've just said 'I'm not suitably qualified to answer this question', 'cos if you start putting things down which you're not sure about you're leaving yourself wide open. (Manchester GP)*

The time constraint imposed by the average length of GP consultations with patients was mentioned by GPs as a limiting factor on the extent to which they can address occupational health problems, although it was also noted that some exploration of a patient's occupation need not be time consuming.

*Ideally yes [occupational health should be addressed in primary care], but training and time, that's the problems – even if we were all trained you're still stuck with 8 minutes per patient whatever the problem. (Sheffield GP)*

The view was expressed that additional time in consultations would probably not increase the extent to which GPs could address occupational health problems, as occupational health knowledge would then become an issue.

A further difficulty GPs mentioned relates to ethical and legal concerns over their relationship with patients and issues of confidentiality. Where patients have access to occupational health provision, GPs can communicate with other health professionals on the patient's behalf. However, many employers do not have any occupational health provision. An associated difficulty is that patients are sometimes afraid of involving their employers' occupational health service, which is perceived as acting in the interests of their employer, whereas GPs are viewed as acting in the interests of the patient.

*I think a lot of patients think that they're on the companies side, they're paid for by the company and therefore they're not going to get a fair hearing. (Sheffield GP)*

The majority of GPs identified a conflict of interest between primary care and occupational health doctors. GPs are the patient's advocate, whereas occupational health physicians attached to companies represent the interests of the employer and getting people back to work quickly.

*Its very rare the company doctors actually takes an active role in the management of patients, they mostly rubber stamp the issue. (Sheffield GP)*

*My view is that they don't seem to do very much, the occupational health doctors. When I came to general practice I rather naively thought, great you've got an occupational health doctor you can go and see them, but really they seem to be as a safeguard to the company rather than actually providing any treatment. We seem to deal with the problem. (Sheffield GP)*

*Our agenda is to make the patients better not to affect the time they have off sick. (Manchester GP)*

*In theory, there is no conflict, because what's in the patient's best interests should be in the interests of the firm. It's an investment in time; if you take a little bit of time off to get the injury sorted out and recuperate properly you'll then actually stay at work longer and not have to come out a later date, both sides benefit. (Manchester GP)*

On the whole, GPs don't communicate directly with employers and tend to leave it to patients to speak to their own employers.

*We don't write to the company, we leave it up to them [patients]. (Sheffield GP)*

*I'd only do it [communicate with company] doctor to doctor, otherwise its too dangerous. (Manchester GP)*

*The only real occupational health dialogue with companies is when things have reached a very difficult stage for the patient, with them having been off for quite an extended length of time and we're having to produce evidence and often give a prognosis: 'when will the person be fit for work', which I find is almost impossible. If something could be done in advance of that point then it would actually be a lot more helpful. (Manchester GP)*

*Sometimes there are patients who you feel are getting a poor deal, where you feel that a simple redeployment or a chat with the occupational health physicians, nurse or line manager might be useful. So that's something I do occasionally but not very often. It's happened once or twice in ten years. (Manchester GP)*

Delayed access to secondary care was cited as another difficulty in addressing occupational health problems for patients. Waiting lists for services, such as stress counselling, prevent people getting back to work sooner. However, it was mentioned that employers need to be more flexible if they want employees to return quickly; they shouldn't expect that employees are 100% fit and explore options such as redeployment, altered work hours or phased return. This criticism was also felt to apply to DSS 'fitness to work' assessments, in that they tend to view fitness in 'all or nothing' terms.

*There are specific things that could be done to improve quickness back to work in terms of improving their condition - having counselling for stress related problems; improved access of primary care to these services. (Manchester GP)*

*I think it's getting worse, the physio waiting list seems to be horrendous. These are all real problems. (Sheffield GP)*

*A lot of time occupational health refers for counselling, we advise the patients to go private, otherwise there is a 5 or 6 month wait; and usually work won't fund it. (Manchester GP)*

*If we could commission services as GPs we would have a better ability to get people back to certain occupations, musculoskeletal in particular - if we could commission quicker services for physio. (Manchester GP)*

*It's not seen as a serious issue for PCT funding. (Sheffield GP)*

### **10.1.7 Local occupational health provision**

Not all of the Sheffield GPs were aware of the Sheffield Occupational Health Advisory Service (SOHAS). A small number of GPs either have a SOHAS adviser presently available at their practice or have had one there previously. Patients can either self refer or be referred by the GP. One of the GPs felt that in their practice, uptake was not very high.

*Used to refer them [patients to occupational health adviser] if we thought their illness was caused by their job. (Sheffield GP)*

Manchester GPs mentioned that they would ideally like to have a simple point of contact for an independent occupational health service.

*It would be nice to have some kind of independent set up [occupational health service] that we could refer them [patients] to. (Manchester GP)*

A number of GPs agreed that there are some 'good' companies with high-quality occupational health provision, and that they are less likely to have to deal with occupational health problems for employees from these companies.

*Some occupational health departments are very good, for example with repetitive strain, they bring in all sorts of gadgets and help*

*I sometimes refer to unions (Sheffield GP)*

*I think in the past employers were a bit more flexible, whereas now unless you're 100% fit they say I'm very sorry but you can't work here anymore*

*Just recently I saw a lady...they [employer] had a new carpet laid; there were a lot of fumes from the glue and it affected her asthma. But she came to tell me that [her manager] had told her to stop off for two weeks while the fumes dissipated; but she wasn't exactly not able to work its just that she couldn't work in that particular environment. (Sheffield GP)*

### **10.1.8 Occupational health provision for GPs**

Knowledge of occupational health provision for GPs appeared to be quite limited. There was a perception that there had been some improvement, along with increased attention to health and safety in primary care (e.g. risk assessments of practices). Mental health problems are regarded as a significant occupational health problem among the GP population, and they would like to see quick access to services where concerns over confidentiality are minimised. One of the Manchester GPs raised concerns over being told that GPs no longer have access to private psychiatric services.

*Depression and stress are very high in primary care and the one thing we had in Manchester was access to private psychiatric services but this has been removed. (Manchester GP)*

*If we are off sick we can't help our patients! (Manchester GP)*

## **10.2 PRACTICE NURSE FOCUS GROUPS: KEY FINDINGS**

### **10.2.1 Occupational health problems**

Practice nurses identified a number of common occupational health problems they encounter in primary care patients. The four most significant problems include:

- Respiratory/Asthma/Chronic Obstructive Pulmonary Disease (COPD). For example, prevalent in bakery workers exposed to flour, mining workers, builders exposed to brick dust, and steel workers exposed to asbestos;
- Musculoskeletal disorders, in particular back pain;
- Mental health problems such as stress and depression;
- Hepatitis B Immunisations for various occupations.

*Depression and stress; especially stress; we deal with people every day, that is really quite a big issue. (Sheffield Practice Nurse)*

*I've had quite a few people with stress at work and their employers are very unsympathetic about that. They either cope or tough it out. So people invent other reasons for not being at work. They don't actually say that its stress and be signed off work for some other reason but*

*very few people still admit that its stress rated. Very few employers seem to be sympathetic towards it. (Sheffield Practice Nurse)*

Other occupational health problems include: dermatitis (e.g. cleaners exposed to chemicals in cleaning products); epilepsy; hearing problems/occupational deafness; and needle stick injuries (e.g. plumber; electricity worker; nursing home employee).

### **10.2.2 Involvement in addressing occupational health**

Practice nurses involvement in addressing occupational health problems for patients includes chronic disease management (e.g. diabetes; heart disease), advising on lifestyle issues such as diet and exercise, and monitoring (e.g. blood pressure). Chronic disease management addresses the impact of a person's occupation on their condition and the implications of their condition for their occupation (e.g. HGV drivers). The practice nurses can also find themselves advising on personal protective equipment (e.g. hearing protection).

*[Occupational health is about] Being able to work at a job they [patients] want; that they're healthy enough to do whatever job they're doing; that injury or health problems don't interfere with them being able to do it. (Sheffield Practice Nurse)*

They are faced with requests for occupational health advice from patients, which they do not always feel equipped to deal with (e.g. a checkout worker with tennis elbow). Where patients' employers have occupational health provision, the practice nurses refer them to this. One nurse had done this in the case of an asthmatic patient who was exposed to passive smoking in the workplace. It was noted, however, that not all companies have occupational health provision, and patients may be afraid to involve their occupational health departments or are afraid to take time off work for consultations. The latter is particularly problematic in relation to chronic disease management check ups.

*Lots of people are frightened of their own occupational health departments; they see them as the police. For example, people come with depression and don't write depression on their sick note and they feel it goes against them at work...they don't want to see occupational health as they feel that they're the company and they're not going to treat them fairly and they're going to get rid of them. (Manchester Practice Nurse)*

*It can be difficult to get time off for chronic [disease] management in low paid jobs; if they're not there they don't get paid. (Sheffield Practice Nurse)*

*I've seen a lot of people diagnosed with diabetes that won't come in, won't go on insulin because they're frightened of losing their job. They might be long distance lorry drivers – they're frightened to be diagnosed and get treatment because of work related issues. They think they'll get the sack if their employers find out and I don't feel in a position that I can give them the information they need or the support they need really. (Sheffield Practice Nurse)*

One of the nurses had experienced an adverse reaction from an employer when it was suggested that an employee's asthma was work related.

*I didn't really know a lot about occupational health when I first started out and I suggested to her [patient] that she mentioned to her employers about ventilation, which she did; and then we had letters from her work. They [employer] did in the end change where she worked. We had a lot of angry letters from her firm for accusing them of being bad employers. (Sheffield Practice Nurse)*

They do ask about and record patients' occupation though this is not always recorded electronically. They also raised the issue of the difficulty in keeping track of patients' changes in job/occupation.

*People change their job so often; we have trouble keeping up with their phone numbers let alone employment. (Manchester Practice Nurse)*

### **10.2.3 Occupational health education and training**

Practice nurses stated that they had no specific training in occupational health, but that their general training included coverage of the occupational aspects of certain conditions, such as asthma.

*[Training] Only in relation to chronic disease management, COPD, diabetes, asthma. You tend to cover - is it an occupational cause or is it a problem continuing work. (Sheffield Practice Nurse)*

It was also felt that their training in how to take a holistic history in patient consultations encourages and helps them to explore occupational issues.

*Practice nurses treat patients holistically. We're not just seeing them for one narrow thing. Often they've got multiple things, especially with chronic disease management; so we're looking at all aspects of their life. (Sheffield Practice Nurse)*

Additional knowledge of occupational health has been acquired 'on the job' depending on the problems they and colleagues have encountered, including their experiences of occupational health problems connected with their own job (e.g. musculoskeletal disorders such as back and hip problems).

*...Most of us have worked several years. Probably without actually knowing that you have developed quite a lot of knowledge of occupational health, but maybe its knowing what to do and where to go with it. (Sheffield Practice Nurse)*

A number of the Sheffield practice nurses mentioned the Public Health and Infection Control Nurses as helpful sources of advice on issues such as the types of gloves they should wear. Other sources of information mentioned included the practitioner publication 'Practice Nursing'.

### **10.2.4 Role of primary care in addressing occupational health problems**

Practice nurses agreed that they should be addressing occupational health in their patient population, as work is a significant part of most people's lives, and an appreciation of occupation is important as part of a holistic appraisal of a patient. They regard it as part of their role in maintaining a healthy population, including keeping people healthy enough to work. It was also felt that patients are more likely to talk about their work with the practice nurses, as they are perceived as having more time.

*It seems to me that people are all going to be working longer...therefore we're going to have to keep them healthier. (Sheffield Practice Nurse)*

*We're in good position to make them [patients] aware of what is available for promoting health, getting them on right track with diabetes or whatever. (Sheffield Practice Nurse)*

However, the view was also expressed that occupational health problems should be dealt with at source, through improved employer provision. They highlighted the need to clarify areas of

responsibility between what employers should be providing, and what primary care and the NHS is expected to provide.

*I think there should be still occupational health provision by their employers to maintain their health. I really think healthcare workers should be provided with HepB by their employers and not by us 'cos that's their employers' responsibility and not ours. (Manchester Practice Nurse)*

*My reticence is that if we're not careful everything should be addressed in primary care. The capacity is not here but having said that I think, yes, there's a lot we can do in primary care about occupational health. We get a lot of it because they [patients] don't know where to go or their workplace doesn't have an occupational health service. But I'm not sure we want to take the whole lot on. (Sheffield Practice Nurse)*

### **10.2.5 Barriers to addressing occupational health**

A number of difficulties were identified as affecting the extent to which practice nurses can address occupational health problems for patients in primary care. The lack of general occupational health knowledge and specific knowledge of the patient's workplace limits the advice they can give.

*I personally feel that I don't know enough about occupations to be able to advise on what they [patients] think they've got. (Sheffield Practice Nurse)*

*I had a [patient] who had some hearing loss; again he was asking me things about his job that I hadn't a clue; again I had to refer him back to his occupational health. (Sheffield Practice Nurse)*

This creates an additional difficulty in that in addition to the time it takes to explore problems with patients, further time is required to seek out information to follow them up. Lack of knowledge is a particular source of concern when dealing with patients who are pursuing compensation claims. Some of the nurses stated that they are particularly cautious in these cases, as they do not feel confident in providing advice about returning to work.

*A lot of people are pursuing claims. I don't feel very confident about that at all and sometimes feel they're expecting us to say 'yes', they can't do a job; and I don't really feel that's our role...You have to be very careful about what you're saying and what advice you give. (Sheffield Practice Nurse)*

Practice nurses were in agreement that they did not want to know everything, commenting that occupational health nursing is a career in itself. They suggested that they needed to be able to link with occupational health workers' expertise, knowing where to refer patients to and how. This could be supported by a simple occupational health flow chart identifying what to do and what referral routes were available.

*As nurses we can't take it all on, we need to know channels to direct people down. (Sheffield Practice Nurse)*

*I'm not sure that we want to know everything 'cos I don't think you can, but its about knowing where to go for information. (Sheffield Practice Nurse)*

*Rather than giving us all the skills, which there's no way we can do that, we need to know where we can get hold of this [occupational health] expertise. (Sheffield Practice Nurse)*

At most, they felt their lack of knowledge could be addressed by a short course covering basic issues (e.g. hazards in different jobs; case studies on specific topics), preferably as training within the Primary Care Trust (PCT). It was suggested that this could be done as part of the Protected Learning Initiative (PLI). Practice nurses were less in favour of having to access information via the internet/intranet due to lack of time.

Lack of knowledge of referral routes for patients with occupational health problems, including the lack of occupational health specialists, was also raised as a difficulty. However, it was felt that this is more of an issue for GPs, as nurses tend to refer to GPs for diagnosis and referrals to specialists.

*I'd like more knowledge about what's available and where to refer people to. (Sheffield Practice Nurse)*

*A lot of places won't take practice nurse referrals; it has to be a GP referral so there's limitations to where we can actually refer. (Manchester Practice Nurse)*

An associated problem is the length of time patients have to wait for secondary care appointments. The nurses did add that some occupational health problems are better catered for in specialist care than others. In both Sheffield and Manchester, occupational asthma was felt to be well catered for by the chest clinics. In Manchester, a 'back school' is now available.

A further problem was identified in connection with increasing time and financial demands from companies referring people to primary care for occupational health provision. Hepatitis B immunisations were felt to be a key example of this, as employers are getting the service free, yet it has resource implications for individual practices. One of the practices now charges for Hepatitis B immunisations.

*Its [referrals from employers' occupational health services] putting more demands on us, and more financial demands on the practice. (Manchester Practice Nurse)*

*I've had people come for dressings and they've been to see the occupational health nurse that said 'you'd better go and see your doctors, I can't dress it for you'; what are they doing. (Manchester Practice Nurse)*

*I've had them been to occupational health for a medical and say 'they've found I've got high blood pressure and sent me to you'; surely they could monitor it for a bit. (Manchester Practice Nurse)*

*We pay for it [Hepatitis B immunisations] because we actually give it as a free service. (Manchester Practice Nurse)*

Employers not accepting self-certification and requiring proof of visits was regarded as an additional demand employers are placing on primary care. One of the nurses mentioned that their practice gives patients a copy of the guidance for employers on sickness certification.

*We had a big issue with [company] where they wouldn't accept self certification and they used to ring every day when one of their employees was off saying we want a doctors note. In the end we said you can have one but you'll have to pay for it and they stopped. It was the only way; their employees were coming in every day, saying 'they sent us here'. (Manchester Practice Nurse)*

### **10.2.6 Local occupational health provision**

Knowledge of the Sheffield Occupational Health Advisory Service (SOHAS) among the Sheffield nurses was found to be quite limited, with only five of the fourteen focus group participants being aware of the service. When they were made aware of SOHAS, Sheffield nurses requested further information as they felt it would be a useful resource for them. Nurses from practices that either previously had or currently have an occupational health advisor from SOHAS available for patients, thought it was a useful service and had referred patients; though one of the nurses felt that the service was not fully utilised.

SOHAS is currently a city-wide service working from over 20 base practices. Over 90% of patients seen by SOHAS, are referred by their GP or another health professional.

*Sheffield Occupational Health Project used to have workers in the practice and then funding was withdrawn. I think the PCTs are funding it now or a certain amount of it so that they [occupational health advisers] do come into practice. They used to sit in the waiting room and ask people about their work history and anything health related; like you I used to find them really useful for referring people that were ill at work; and also they were from a trade union background so claims and benefits and things like that, they could advise people on. They did hearing tests, which was quite good as well. (Sheffield Practice Nurse)*

Manchester practice nurses indicated that they would find it helpful to have an occupational health specialist based locally or in the practice.

*I think possibly we need an area occupational health service; employers would probably have to pay for it. A private occupational health service outside of the NHS but linked. (Manchester Practice Nurse)*

### **10.2.7 Occupational health provision for practice nurses**

On the subject of occupational health provision for practice nurses, it was felt that there has been some improvement (e.g. protocol for needle stick injuries, checking immunisations). Some practices tend to address occupational health problems such as needle stick injuries within the practice.

*We've [Practice Nurses] only just got occupational health. I actually had a needle stick injury; I tried to go through the right channels and got blocked. I couldn't get advice, but now we have occupational health and somewhere to go. (Sheffield Practice Nurse)*

Manchester practice nurses were aware of, or had received manual handling training; DSE assessments; relaxation; and courses in stress management. Some Manchester practices noted that their occupational health provision was not easily accessible because of its geographical location.

## **10.3 PRACTICE MANAGER FOCUS GROUPS: KEY FINDINGS**

### **10.3.1 Occupational health problems**

Hepatitis B immunisations, stress related problems and musculoskeletal disorders were perceived by managers to be the most common occupational health problem presented by patients at their practices. It was noted, however, that it is difficult to determine the extent of occupational health problems they deal with in primary care.

*If it's an occupational health related problem we don't actually record it as an occupational health related problem, we record it as a problem so it's very difficult to judge what is the demand out there. (Manchester Practice Manager)*

On the subject of Hepatitis B immunisations, the cost and time implications of providing this service for employers were raised.

*We do a lot of occupational health for patients in primary care, even for organisations that have occupational health set up, especially around vaccination and immunisation, and stress. A lot of large companies still come to GPs for occupational health.* (Manchester Practice Manager)

### **10.3.2 Involvement in addressing occupational health**

Discussion of practice managers' involvement in addressing occupational health for patients initially indicated that they had minimal involvement. Their main contribution relating to requests for medical reports. They ensure that patient records are sent to occupational health departments with the patient's consent and charge companies for this service. However, it emerged that they are actually involved in various aspects of occupational health provision for patients. For example, they have input into decisions to purchase services such as physiotherapy and counselling, which although not specifically targeted at patients with occupational health problems, are available to them. It was noted that not all practices could afford to buy in such services. Primary Care Trust (PCT) managers can also influence provision of such services. For example, one of the Manchester PCTs has set up a specialised back clinic, which will address work related and non-work related back pain.

Practice managers also contribute to patient education through the provision of leaflets, newsletters, posters and websites, some of which can address occupational health issues (e.g. occupational deafness, vibration white finger). It was suggested that communication of occupational health information through leaflets and posters in practice waiting rooms may not be that effective, as the information gets lost in a 'sea' of other leaflets and posters. One of the practice managers had a considerable level of involvement and interest in patient education and information, to the extent that they had carried out a project for the PCT examining the needs of patients with learning difficulties.

*We do put leaflets out on various subjects, some of them are related to occupational health issues; smoking and drinking – don't drive machinery after drinking.* (Manchester Practice Manager)

*I actually try and do focus boards but its still a sea of posters.* (Sheffield Practice Manager)

*I think generally we all struggle to get information to patients; the practice leaflet tends to be the main source. Any other way usually involves spending a lot of money, which is limited.* (Sheffield Practice Manager)

*It's a question of cost isn't it; you couldn't send it [newsletter] to everybody.* (Sheffield Practice Manager)

Some practices also run patient education and health promotion events, although the managers concerned had not always considered the potential for addressing occupational health issues, such as the work related aspects of chronic disease management. Practice managers can also influence decisions regarding the co-operation of practices in occupational health studies. For example, one manager had supported the involvement of their practice in a study examining the content of patient sick notes. They also have input into the provision of training for staff in primary care, including Protected Learning Initiatives (PLIs).

### **10.3.3 Occupational health education and training**

Practice managers primary role in relation to occupational health is one of concern for staff in primary care within the context of a general responsibility for health and safety. They have received some training for health and safety. Some Manchester managers had received training in topics such as risk assessment; COSHH; RIDDOR, and specific occupational health issues (e.g. stress). They were also sent occupational health packs 4-5 years ago, though managers joining more recently had not been sent one. Some practices had also conducted in-house health and safety training. However, the overall view seemed to be that practice managers are not as well informed as they could be on occupational health issues, with much of their knowledge acquired by word of mouth. Other sources individuals had used included the Internet (e.g. the BMA site for information on employment law), Human Resources at the Health Authority, and SOHAS.

### **10.3.4 Role of primary care in addressing occupational health problems**

On the subject of the extent to which primary care can address occupational health for its patients, many of the practice managers felt that occupational health provision is beyond the scope and capability of primary care. They identified a need for greater occupational health provision by employers, with occupational health specialists who take responsibility for making decisions about employees rather than passing this responsibility to primary care.

*On the whole we are on the receiving end of things from the [patients employers] occupational health department. We get a lot of requests for 'fitness to work' reports, which seems pointless having the occupational health departments there. They know the workplace better than GPs and yet they're still referring to their GP to see whether they're [employee/patient] fit to perform duties. (Manchester Practice Manager)*

*It's sort of like a tennis match. Neither one wants to be the one who says this person can no longer work in particular area. (Manchester Practice Manager)*

It was also mentioned that addressing occupational health problems at source might lessen the load on primary care. At present, they regard occupational health departments as adding to the workload of primary care, particularly through requests for sickness certification. This is compounded by a lack of clarity regarding the respective responsibilities of the NHS/primary care and employers.

*Some employers won't accept a self-certificate; the patient has to come to the doctor to get a sick note, which is in additional workload. (Manchester Practice Manager)*

The need to educate both employers and patients on the use of services was also raised. Two main problems were identified in relation to employers' provision of occupational health services. First, employees are often afraid to seek help from employers' occupational health services. Second, many companies do not have any occupational health provision for their employees.

### **10.3.5 Barriers to addressing occupational health**

Practice managers identified a number of difficulties they perceive to affect the extent to which occupational health problems can be addressed for patients in primary care. For GPs, it was considered that short consultation times limit the extent to which they can address occupational health problems for patients. It was also felt that they couldn't be expected to know about the various work environments and employment law.

*I think there should be some awareness of it [occupational health] but whether there's time for GPs to talk about it, that's an issue. (Sheffield Practice Manager)*

Additional difficulties related to issues of patient confidentiality and an apparent conflict of interest between primary care and employers' occupational health provision, the latter being more concerned with reducing their sickness absence.

Referral routes for access to specialist services, including occupational health specialists, were also felt to need addressing to ensure that patients could get problems dealt with quickly. This included funding available to practices for services such as counselling, physiotherapy, occupational health advisors, and physical space to house such services.

*We're not in the position that we have funds to buy in services; that was the position when we were fund holding and we certainly did buy in an osteopath and physio as the hospital waiting lists were so long but that's not available to us anymore. (Manchester Practice Manager)*

*The PCT within the physiotherapy role has identified that there is a back pain problem and actually set up a back pain clinic, separate to physio. (Manchester Practice Manager)*

### **10.3.6 Local occupational health provision**

Some of the Sheffield practices have an occupational health advisor from the Sheffield Occupational Health Advisory Service (SOHAS) available within their practice on a fortnightly basis. One practice pays for this service. Patients can either self refer or be referred by staff in the practice. Consultations are confidential between the occupational health worker and the patient. One practice that previously had an occupational health advisor employed a system whereby patients completed a card to record their visit, which was placed in their medical file. There were variable reports of service utilisation: one manager regarded the uptake as good and thought it lightens the GPs workload, whilst in another practice it was felt to be under-utilised at present.

*We do actually have someone in the practice once a fortnight who offers occupational health...he started a few months ago but its not really taken off that well. He probably only sees, maybe three people. He feels that if he saw the doctors and got more referrals from the doctor then he would be able to help but the problem is the doctors say in 7½ minutes they don't have the time...I'm aware that he could do so much to help but he's sat there and nothings being done. (Sheffield Practice Manager)*

*I think in the primary care setting there's certainly a place for this [occupational health provision for patients]. My take on it is, I see the occupational health adviser as a bit of a halfway house, rather than seeing the GP about something, the worker at our practice is a specialist in what he advises on. (Sheffield Practice Manager)*

*The doctors chose long ago to buy in services for patients like occupational health. I genuinely think that, overall the doctors think they get good value for money in terms of helping to lighten their workload in that people will be seeing the occupational health worker rather than taking consultation time. It's another resource. (Sheffield Practice Manager)*

*Just getting occupational health workers, it's not just about funding, it's the supply of people coming through. (Sheffield Practice Manager)*

It was suggested that there could be PCT rather than practice based occupational health provision; preferably one centre that a number surgeries could access, within easy travelling distance for local population. Manchester practice managers suggested a service not dissimilar to that currently provided in Sheffield by SOHAS - an occupational health drop in

centre/service with an independent occupational health service, accessible through multiple avenues (e.g. phone; drop in; internet).

*I think these services [occupational health provision for patients] should be more PCT based. They should have one centre that several surgeries can access rather than having 3 hours, 1 day a week. He [occupational health adviser] should be there for all practices. Its brilliant if you've got it in your surgery but if the surgery next door doesn't have it, its unfair. (Sheffield Practice Manager)*

### **10.3.7 Occupational health provision for primary care staff**

Practice managers did identify some improvement in occupational health provision for staff in primary care. However, it was also clear that there are variable levels of awareness of available provision. Some of the managers from Manchester regard their occupational health service to be under staffed and difficult to access due to location. Manchester practice managers mentioned that the PCTs had recently funded occupational health provision, but they felt the provision could have been better. The provision they were aware of included checking the immunisation status of staff, and flu and hepatitis injection services.

*When it [occupational health service for primary care staff] was launched there was a great deal of interest and somehow it never really evolved, for our practice anyway. Because it was physically based in North Manchester we didn't feel it was close enough to send people for injections. We used to just do the injections in our surgery. (Manchester Practice Manager)*

Managers indicated that they would like to be better informed of new developments (e.g. updates on new health and safety legislation) and where to get information on specific issues for staff (e.g. violence). The need to consider privacy issues was raised in relation addressing occupational health problems for staff in primary care. There is a desire for local provision but this needs to ensure confidentiality.

*If they [occupational health service for primary care staff] could send out updates of health and safety regulations that are coming into force to help keep people up to date, as they are changing all the time. (Manchester Practice Manager)*

## 11 APPENDIX 7: QUESTIONNAIRE RESULTS

### 11.1 DEMOGRAPHICS

The questionnaire respondents had worked in General Practice for a mean of 16 years (range from 2 years to 40 years). 57% of respondents were male and 43% female.

#### 11.1.1 Occupational Health qualifications and information

Table 11.1a shows the breakdown of how many of the GPs surveyed had any Occupational Health qualifications. Seven of the GPs had achieved a Diploma in Occupational Medicine (Dip OM), one an Associate fellow of Occupational Medicine qualification (AFOM), one had a certificate in occupational medicine, and one GP had stated that they had a Institute of Occupational Medicine training course certificate. The remaining four GPs did not state which qualification they had achieved. The questionnaire asked GPs, where they obtained information on occupational health (table 11.1b), and most GPs responded that information was obtained from colleagues

**Table 11.1a** Demographics of occupational Health Qualifications held

	DO YOU HAVE ANY OCCUPATIONAL HEALTH QUALIFICATION OR MEMBERSHIP?		ARE YOU PURSUING ANY OCCUPATIONAL HEALTH QUALIFICATION OR MEMBERSHIP?	
	COUNT	%	COUNT	%
NO	282	95.6%	289	98.3%
YES	13	4.4%	5	1.7%
TOTAL	295	100.0%	294	100.0%

**Table 11.1b** Source of information on Occupational Health

	OBTAINED OCCUPATIONAL HEALTH INFORMATION FROM COLLEAGUES		OBTAINED OCCUPATIONAL HEALTH INFORMATION ON THE JOB		OBTAINED OCCUPATIONAL HEALTH INFORMATION FROM TRAINING		OBTAINED OCCUPATIONAL HEALTH INFORMATION FROM PUBLICATIONS	
	COUNT	%	COUNT	%	COUNT	%	COUNT	%
NO	146	49.8%	78	26.6%	246	84.5%	247	85.2%
YES	147	50.2%	215	73.4%	45	15.5%	43	14.8%
TOTAL	293	100.0%	293	100.0%	291	100.0%	290	100.0%

## 11.2 PATIENT CONSULTATIONS

The questionnaire asked two questions regarding whether GPs asked about the patients occupation in consultations, and whether the patients occupation was recorded in the medical records. Table 11.2a shows the breakdown to the question ‘How often do you ask about a patients occupation’ and table 11.2b whether this information is recorded. In total 81% (239/294) of respondents ‘always’ or ‘often’ asked about a patients occupation, and in total 79% (228/288) recorded the patients occupation in their records.

**Table 11.2a** Frequency of GPs asking about patient’s occupation

HOW OFTEN DO YOU ASK ABOUT A PATIENTS OCCUPATION IN CONSULTATIONS?		
	COUNT	%
RARELY	3	1.0%
OCCASIONALLY	52	17.7%
OFTEN	219	74.5%
ALWAYS	20	6.8%
TOTAL	294	100.0%

**Table 11.2b** Frequency of GPs recording patient occupation in medical records

HOW OFTEN DO YOU ASK ABOUT A PATIENTS OCCUPATION IN CONSULTATIONS?								
RARELY		OCCASIONALLY		OFTEN		ALWAYS		
DO YOU RECORD PATIENTS OCCUPATION IN YOUR MEDICAL RECORDS?		DO YOU RECORD PATIENTS OCCUPATION IN YOUR MEDICAL RECORDS?		DO YOU RECORD PATIENTS OCCUPATION IN YOUR MEDICAL RECORDS?		DO YOU RECORD PATIENTS OCCUPATION IN YOUR MEDICAL RECORDS?		
	COUNT	%	COUNT	%	COUNT	%	COUNT	%
NO			16	30.8%	40	18.7%	4	21.1%
YES	2	100.0%	36	69.2%	174	81.3%	15	78.9%
TOTAL	2	100.0%	52	100.0%	214	100.0%	19	100.0%

### 11.3 FREQUENCY OF OCCUPATIONAL HEALTH PROBLEMS ENCOUNTERED

Table 11.3a and b shows the frequency of the occurrence of occupational health problems. The main health problems encountered at least once a week were musculoskeletal (50% of respondents 145/293) and mental health problems (48% of respondents 140/291). Occupational respiratory, skin, hearing and visual problems were usually encountered less than once a month. Other occupational conditions (as free text) included, bullying, irritable bowel syndrome, farming injuries (including farmers lung), accidents and injuries at work, repetitive strain injury, trauma, tumours and horse related injuries.

**Table 11.3a** Frequency of occurrence of occupational health problems

	TO WHAT EXTENT DO YOU ENCOUNTER WORK RELATED MUSCULOSKELETAL PROBLEMS IN PATIENT CONSULTATIONS?		TO WHAT EXTENT DO YOU ENCOUNTER WORK RELATED SKIN HEALTH PROBLEMS IN PATIENT CONSULTATIONS?		TO WHAT EXTENT DO YOU ENCOUNTER WORK RELATED RESPIRATORY PROBLEMS IN PATIENT CONSULTATIONS?	
	COUNT	%	COUNT	%	COUNT	%
LESS THAN ONCE A MONTH	15	5.1%	153	52.4%	194	66.4%
ONCE A MONTH	58	19.8%	68	23.3%	49	16.8%
ONCE A FORTNIGHT	75	25.6%	35	12.0%	28	9.6%
ONCE A WEEK	84	28.7%	29	9.9%	7	2.4%
DAILY	61	20.8%	7	2.4%	14	4.8%
TOTAL	293	100.0%	292	100.0%	292	100.0%

**Table 11.3b** Frequency of occurrence of occupational health problems

	TO WHAT EXTENT DO YOU ENCOUNTER WORK RELATED HEARING PROBLEMS IN PATIENT CONSULTATIONS?		TO WHAT EXTENT DO YOU ENCOUNTER WORK RELATED MENTAL HEALTH PROBLEMS IN PATIENT CONSULTATIONS?		TO WHAT EXTENT DO YOU ENCOUNTER WORK RELATED VISUAL/EYE PROBLEMS IN PATIENT CONSULTATIONS?	
	COUNT	%	COUNT	%	COUNT	%
LESS THAN ONCE A MONTH	227	78.3%	16	5.5%	212	73.4%
ONCE A MONTH	42	14.5%	60	20.6%	55	19.0%
ONCE A FORTNIGHT	10	3.4%	75	25.8%	14	4.8%
ONCE A WEEK	9	3.1%	83	28.5%	8	2.8%
DAILY	2	.7%	57	19.6%		
TOTAL	290	100.0%	291	100.0%	289	100.0%

Respondents were divided into two groups. Group 1 was those individuals who ‘rarely’ or ‘occasionally’ asked about a patients occupation in consultations, and group 2 those who ‘often’ or ‘always’ asked. A Mantel-Haenszel common Odds ratio estimate was calculated to determine whether GPs who ‘often’ or ‘always’ asked about the patients occupation, were more likely to encounter occupational health problems more than once a fortnight (table 11.3c). Individuals who ‘often’ or ‘always’ asked about occupation, were twice as likely (odds ratio = 2.11 [confidence interval 1.27-3.93]) to see patients with mental health once a fortnight or more, than those ‘rarely’ or ‘occasionally’ asked. This exercise was repeated splitting the respondents into ‘those who do not record patients occupation in consultation’ and ‘those who do record patients occupation in consultation’. Neither of these groups were more likely to encounter occupational health problems more than once a fortnight.

**Table 11.3c** Odds Ratio and 95% confidence intervals for frequency of encountering occupational health problems

	Control ‘those who rarely or occasionally ask about occupation’ n= 55 Cases ‘those who often or always ask about occupation’ n= 237		Control ‘those who do not record patients occupation in consultation’ n=59 Cases ‘those who do record patients occupation in consultation’ n= 227	
Indices	OR†	CI*	OR†	CI*
Musculoskeletal				
Less than once a fortnight	1		1	
Once a fortnight or more	1.79	0.95-3.37	0.91	0.46-1.77
Skin				
Less than once a fortnight	1		1	
Once a fortnight or more	2.03	0.91-4.53	1.29	0.64-2.60
Respiratory				
Less than once a fortnight	1		1	
Once a fortnight or more	2.18	0.82-5.79	1.29	0.57-2.93
Hearing				
Less than once a fortnight	1		1	
Once a fortnight or more	2.22	0.50-9.85	1.13	0.37-3.49
Mental Health				
Less than once a fortnight	1		1	
Once a fortnight or more	2.11	1.13-3.93	0.67	0.33-1.35
Visual/Eye				
Less than once a fortnight	1		1	
Once a fortnight or more	2.37	0.54-10.48	1.11	0.36-3.43
Vaccinations				
Less than once a fortnight	1		1	
Once a fortnight or more	2.61	0.59-11.46	1.31	0.43-4.0

† OR Odds ratio

CI\* Confidence interval

Table 11.3d and 11.3e shows the extent with which the frequency of the occurrence of occupational health problems has changed in the last 18 months. Over 70% of respondents saw no change in the frequency of which they encountered occupational musculoskeletal, skin health, respiratory, hearing, and visual problems and vaccinations. Over half the respondents however (58% 169/292), saw an increase in work related mental health problems.

**Table 11.3d** Change in frequency of the occurrence of occupational health problems

	HAVE YOU NOTICED ANY CHANGE IN THE LAST 18 MONTHS IN THE EXTENT TO WHICH YOU ENCOUNTER WORK RELATED MUSCULOSKELETAL PROBLEMS IN PATIENT CONSULTATIONS?		HAVE YOU NOTICED ANY CHANGE IN THE LAST 18 MONTHS IN THE EXTENT TO WHICH YOU ENCOUNTER WORK RELATED SKIN HEALTH PROBLEMS IN PATIENT CONSULTATIONS?		HAVE YOU NOTICED ANY CHANGE IN THE LAST 18 MONTHS IN THE EXTENT TO WHICH YOU ENCOUNTER WORK RELATED RESPIRATORY PROBLEMS IN PATIENT CONSULTATIONS?	
	COUNT	%	COUNT	%	COUNT	%
INCREASE	79	27.1%	22	7.6%	22	7.6%
NO CHANGE	207	71.1%	259	89.9%	257	88.9%
DECREASE	5	1.7%	7	2.4%	10	3.5%
TOTAL	291	100.0%	288	100.0%	289	100.0%

**Table 11.3e** Change in frequency of the occurrence of occupational health problems

	HAVE YOU NOTICED ANY CHANGE IN THE LAST 18 MONTHS IN THE EXTENT TO WHICH YOU ENCOUNTER WORK RELATED HEARING PROBLEMS IN PATIENT CONSULTATIONS?		HAVE YOU NOTICED ANY CHANGE IN THE LAST 18 MONTHS IN THE EXTENT TO WHICH YOU ENCOUNTER WORK RELATED MENTAL HEALTH PROBLEMS IN PATIENT CONSULTATIONS?		HAVE YOU NOTICED ANY CHANGE IN THE LAST 18 MONTHS IN THE EXTENT TO WHICH YOU ENCOUNTER WORK RELATED VISUAL/EYE PROBLEMS IN PATIENT CONSULTATIONS?	
	Count	%	Count	%	Count	%
Increase	6	2.1%	169	57.9%	9	3.1%
No change	271	93.8%	123	42.1%	270	93.8%
Decrease	12	4.2%			9	3.1%
Total	289	100.0%	292	100.0%	288	100.0%

Respondents were again divided into two groups determined by the length of time they had spent in practice (group 1 less than 16 years, group 2 more than or equal to 16 years). Odds ratio estimate was calculated to determine whether GPs who had spent less than 16 years in practice were more likely to encounter occupational health problems more than once a fortnight (table 11.3f). Neither of these groups were more likely to encounter occupational health problems more than once a fortnight.

This exercise was again repeated splitting the respondents by gender. From the analysis it can be seen that male GPs are more likely to see patients with musculoskeletal, respiratory or hearing problems than females, however the converse is true for mental health problems.

**Table 11.3f** Odds Ratio and 95% confidence intervals for frequency of encountering occupational health problems

	Control 'those who have spent less than 16 years in practice' n= 137 Cases 'those who have spent more than 16 years in practice' n= 156		Control 'males' n=166 Cases 'females' n=123	
Indices	OR†	CI*	OR†	CI*
<b>Musculoskeletal</b>				
Less than once a fortnight	1		1	
Once a fortnight or more	0.99	0.58-1.68	0.48	0.28-0.82
<b>Skin</b>				
Less than once a fortnight	1		1	
Once a fortnight or more	0.69	0.41-1.18	0.65	0.37-1.13
<b>Respiratory</b>				
Less than once a fortnight	1		1	
Once a fortnight or more	1.07	0.58-1.98	0.33	0.16-0.67
<b>Hearing</b>				
Less than once a fortnight	1		1	
Once a fortnight or more	1.45	0.58-3.62	0.21	0.06-0.72
<b>Mental Health</b>				
Less than once a fortnight	1		1	
Once a fortnight or more	0.74	0.43-1.250	1.79	1.03-3.12
<b>Visual/Eye</b>				
Less than once a fortnight	1		1	
Once a fortnight or more	1.56	0.64-3.85	0.59	0.23-1.5
<b>Vaccinations</b>				
Less than once a fortnight	1		1	
Once a fortnight or more	1.84	0.76-4.45	0.51	0.21-1.28

† OR Odds ratio

CI\* Confidence interval

## 11.4 BARRIERS TO ADDRESSING OCCUPATIONAL HEALTH PROBLEMS

Table 11.4a and table 11.4b shows the breakdown of the barriers to addressing occupational health problems.

**Table 11.4a** Barriers to addressing occupational health problems

	DOES LACK OF TRAINING MAKE IT DIFFICULT FOR YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?		DOES THE CONSULTATION TIME MAKE IT DIFFICULT FOR YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?		DOES LACK OF REFERRAL ROUTES MAKE IT DIFFICULT FOR YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?	
	COUNT	%	COUNT	%	COUNT	%
NO	117	40.5%	108	37.4%	123	42.6%
YES	172	59.5%	181	62.6%	166	57.4%
TOTAL	289	100.0%	289	100.0%	289	100.0%

**Table 11.4b** Barriers to addressing occupational health problems

	DO WAITING TIMES FOR SPECIALIST SERVICES MAKE IT DIFFICULT FOR YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?		DOES CONFLICT OF INTEREST MAKE IT DIFFICULT FOR YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?		DOES CONFIDENTIALITY MAKE IT DIFFICULT FOR YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?	
	COUNT	%	COUNT	%	COUNT	%
NO	96	33.2%	229	79.2%	240	83.0%
YES	193	66.8%	60	20.8%	49	17.0%
TOTAL	289	100.0%	289	100.0%	289	100.0%

Odds ratio estimate was calculated to determine which groups of individuals were more likely to perceive lack of training, consultation times, lack of referral routes, waiting times for specialists, conflict of interest or confidentiality as a barrier to occupational health. Individuals who recorded the patients occupation in their medical records twice as likely (odds ratio 2.62 [confidence interval 1.07-6.45]) to consider ‘conflict of interest’ as a barrier to addressing occupational health problems (table 11.4c). Individuals who had worked for more than 16 years, were less likely to perceive training (odds ratio = 0.49 [confidence interval 0.30-0.79]) or conflict of interest (odds ratio = 0.46 [confidence interval 0.26-0.82]) as a barrier than those who had worked for longer. Individuals who ‘often’ or ‘always asked about occupation, were twice as likely (odds ratio = 2.13 [confidence interval 1.16-3.93]) to perceive ‘lack of referral routes’ as a barrier than those who ‘rarely’ or ‘occasionally’ asked (table 11.4d)

**Table 11.4c** Odds Ratio and 95% confidence intervals for perceived barriers to occupational health.

Indices	Control ‘those who do not record patients occupation in consultation’ n=58 Cases ‘those who do record patients occupation in consultation’ n= 224		Control ‘those who have spent less than 16 years in practice’ n= 134 Cases ‘those who have spent more than 16 years in practice’ n= 155	
	OR†	CI*	OR†	CI*
Lack of training				
No	1		1	
Yes	0.96	0.53-1.73	0.49	0.30-0.79
Consultation time				
No	1		1	
Yes	0.83	0.45-1.52	0.7	0.43-1.13
Lack of referral routes				
No	1		1	
Yes	0.76	0.42-1.37	0.84	0.53-1.34
Waiting times for specialist services				
No	1		1	
Yes	1.07	0.58-1.96	0.85	0.52-1.4
Conflict of interest				
No	1		1	
Yes	2.62	1.07-6.45	0.46	0.26-0.82
Confidentiality				
No	1		1	
Yes	1.28	0.56-2.91	0.88	0.48-1.63

† OR Odds ratio

CI\* Confidence interval

**Table 11.4d** Odds Ratio and 95% confidence intervals for perceived barriers to occupational health.

	Control 'those who rarely or occasionally ask about occupation' n= 55 Cases 'those who often or always ask about occupation' n= 237		Control 'males' n=166 Cases 'females' n=123	
Indices	OR†	CI*	OR†	CI*
Lack of training				
No	1		1	
Yes	0.83	0.44-1.54	1.10	0.68-1.78
Consultation time				
No	1		1	
Yes	1.05	0.57-1.95	1.26	0.77-2.05
Lack of referral routes				
No	1		1	
Yes	2.13	1.16-3.93	0.98	0.61-1.58
Waiting times for specialist services				
No	1		1	
Yes	0.97	0.51-1.83	1.31	0.79-2.16
Conflict of interest				
No	1		1	
Yes	1.32	0.60-2.88	1.89	1.06-3.38
Confidentiality				
No	1		1	
Yes	1.71	0.69-4.26	1.28	0.68-2.4

† OD Odds ratio

CI\* Confidence interval

## 11.5 STRATEGIES TO HELP GPs TO ADDRESS OCCUPATIONAL HEALTH PROBLEMS

Table 11.5a and table 11.5b shows the breakdown of what GPs perceive would help address occupational health problems.

**Table 11.5a** Frequency of what GPs perceive would help address occupational health problems.

	WOULD TRAINING HELP YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?		WOULD LONGER PATIENT APPOINTMENT TIMES HELP YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?		WOULD INFORMATION SHEETS/LEAFLETS HELP YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?	
	COUNT	%	COUNT	%	COUNT	%
NO	110	37.9%	137	47.4%	123	42.4%
YES	180	62.1%	152	52.6%	167	57.6%
TOTAL	290	100.0%	289	100.0%	290	100.0%

**Table 11.5b** Frequency of what GPs perceive would help address occupational health problems.

	WOULD INCREASED REFERRAL ROUTES HELP YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?		WOULD SPEEDIER ACCESS TO SECONDARY CARE HELP YOU TO ADDRESS PATIENTS OCCUPATIONAL HEALTH PROBLEMS?	
	COUNT	%	COUNT	%
NO	98	33.8%	76	26.3%
YES	192	66.2%	213	73.7%
TOTAL	290	100.0%	289	100.0%

Odds ratio estimate was calculated to determine which groups of individuals were more likely to perceive that training, longer patient times, information sheets, increased referral routes, or speedier access to secondary care would help them address occupational health problems. Individuals who had worked for more than 16 years, were less likely to perceive ‘training’ (odds ratio = 0.49 [confidence interval 0.30-0.80]) would help address patients occupational health problems than those who had worked for less time. Individuals who ‘often’ or ‘always asked about occupation, were twice as likely (odds ratio = 2.66 [confidence interval 1.45-4.88]) to perceive ‘increased referral routes’ would help address occupational health than those who ‘rarely’ or ‘occasionally’ asked. Interestingly, female GPs were more likely to find information sheets useful than men (odds ratio = 1.63 [confidence interval 1.00-2.63])

**Table 11.5 c** Odds Ratio and 95% confidence intervals for strategies to help GPs to address occupational health problems

Indices	Control ‘those who do not record patients occupation in consultation’ n=58 Cases ‘those who do record patients occupation in consultation’ n= 224		Control ‘those who have spent less than 16 years in practice’ n= 134 Cases ‘those who have spent more than 16 years in practice’ n= 156	
	OR†	CI*	OR†	CI*
<b>Training</b>				
No	1		1	
Yes	1.19	0.66-2.13	0.49	0.30-0.80
<b>Longer patient appointment times</b>				
No	1		1	
Yes	0.87	0.49-1.56	0.82	0.52-1.31
<b>Information sheets/leaflets</b>				
No	1		1	
Yes	1.75	0.98-3.14	0.64	0.4-1.02
<b>Increased referral routes</b>				
No	1		1	
Yes	0.62	0.32-1.19	1.18	0.73-1.93
<b>Speedier access to secondary care</b>				
No	1		1	
Yes	1.09	0.57-2.09	0.92	0.54-1.55

† OD Odds ratio

CI\* Confidence interval

**Table 11.5 d** Odds Ratio and 95% confidence intervals for strategies to help GPs to address occupational health problems

	Control 'those who rarely or occasionally ask about occupation' n= 55 Cases 'those who often or always ask about occupation' n= 237		Control 'males' n=166 Cases 'females' n=120	
Indices	OR†	CI*	OR†	CI*
<b>Training</b>				
No	1		1	
Yes	1.08	0.59-2.0	0.8	0.49-1.3
<b>Longer patient appointment times</b>				
No	1		1	
Yes	0.98	0.54-1.78	1.0	0.62-1.6
<b>Information sheets/leaflets</b>				
No	1		1	
Yes	0.86	0.47-1.58	1.63	1.00-2.63
<b>Increased referral routes</b>				
No	1		1	
Yes	2.66	1.45-4.88	1.24	0.75-2.04
<b>Speedier access to secondary care</b>				
No	1		1	
Yes	0.89	0.45-1.77	0.91	0.54-1.55

† OD Odds ratio

CI\* Confidence interval

## 11.6 WHAT LOCAL SERVICES DO GPs USE FOR REFERRAL OF PATIENTS

**Table 11.5a** Frequency of services used for referral of patients with occupational health problems

	DO YOU USE SPECIALIST PRIMARY CARE SERVICES FOR PATIENTS WITH WORK RELATED MUSCULOSKELETAL PROBLEMS?		DO YOU USE SPECIALIST SECONDARY CARE SERVICES FOR PATIENTS WITH WORK RELATED MUSCULOSKELETAL PROBLEMS?		DO YOU USE OCCUPATIONAL HEALTH SERVICES FOR PATIENTS WITH WORK RELATED MUSCULOSKELETAL PROBLEMS?	
	COUNT	%	COUNT	%	COUNT	%
NO	179	62.8%	96	33.7%	236	82.8%
YES	106	37.2%	189	66.3%	49	17.2%
TOTAL	285	100.0%	285	100.0%	285	100.0%

**Table 11.5b** Frequency of services used for referral of patients with occupational health problems

	DO YOU USE SPECIALIST PRIMARY CARE SERVICES FOR PATIENTS WITH WORK RELATED SKIN PROBLEMS?		DO YOU USE SPECIALIST SECONDARY CARE SERVICES FOR PATIENTS WITH WORK RELATED SKIN PROBLEMS?		DO YOU USE OCCUPATIONAL HEALTH SERVICES FOR PATIENTS WITH WORK RELATED SKIN PROBLEMS?	
	COUNT	%	COUNT	%	COUNT	%
NO	228	80.9%	49	17.4%	267	94.7%
YES	54	19.1%	233	82.6%	15	5.3%
TOTAL	282	100.0%	282	100.0%	282	100.0%

**Table 11.5c** Frequency of services used for referral of patients with occupational health problems

	DO YOU USE SPECIALIST PRIMARY CARE SERVICES FOR PATIENTS WITH WORK RELATED RESPIRATORY PROBLEMS?		DO YOU USE SPECIALIST SECONDARY CARE SERVICES FOR PATIENTS WITH WORK RELATED RESPIRATORY PROBLEMS?		DO YOU USE OCCUPATIONAL HEALTH SERVICES FOR PATIENTS WITH WORK RELATED RESPIRATORY PROBLEMS?	
	COUNT	%	COUNT	%	COUNT	%
NO	242	85.5%	44	15.5%	269	95.1%
YES	41	14.5%	239	84.5%	14	4.9%
TOTAL	283	100.0%	283	100.0%	283	100.0%

**Table 11.5d** Frequency of services used for referral of patients with occupational health problems

	DO YOU USE SPECIALIST PRIMARY CARE SERVICES FOR PATIENTS WITH WORK RELATED HEARING PROBLEMS?		DO YOU USE SPECIALIST SECONDARY CARE SERVICES FOR PATIENTS WITH WORK RELATED HEARING PROBLEMS?		DO YOU USE OCCUPATIONAL HEALTH SERVICES FOR PATIENTS WITH WORK RELATED HEARING PROBLEMS?	
	COUNT	%	COUNT	%	COUNT	%
NO	263	92.3%	27	9.5%	272	95.4%
YES	22	7.7%	258	90.5%	13	4.6%
TOTAL	285	100.0%	285	100.0%	285	100.0%

**Table 11.5e** Frequency of services used for referral of patients with occupational health problems

	DO YOU USE SPECIALIST PRIMARY CARE SERVICES FOR PATIENTS WITH WORK RELATED MENTAL HEALTH PROBLEMS?		DO YOU USE SPECIALIST SECONDARY CARE SERVICES FOR PATIENTS WITH WORK RELATED MENTAL HEALTH PROBLEMS?		DO YOU USE OCCUPATIONAL HEALTH SERVICES FOR PATIENTS WITH WORK RELATED MENTAL HEALTH PROBLEMS?	
	COUNT	%	COUNT	%	COUNT	%
NO	188	66.4%	81	28.6%	241	85.2%
YES	95	33.6%	202	71.4%	42	14.8%
TOTAL	283	100.0%	283	100.0%	283	100.0%

**Table 11.5f** Frequency of services used for referral of patients with occupational health problems

	DO YOU USE SPECIALIST PRIMARY CARE SERVICES FOR PATIENTS WITH WORK RELATED VISUAL/EYE PROBLEMS?		DO YOU USE SPECIALIST SECONDARY CARE SERVICES FOR PATIENTS WITH WORK RELATED VISUAL/EYE PROBLEMS?		DO YOU USE OCCUPATIONAL HEALTH SERVICES FOR PATIENTS WITH WORK RELATED VISUAL/EYE PROBLEMS?	
	COUNT	%	COUNT	%	COUNT	%
NO	233	82.3%	62	21.9%	265	93.6%
YES	50	17.7%	221	78.1%	18	6.4%
TOTAL	283	100.0%	283	100.0%	283	100.0%

## 11.7 OCCUPATIONAL HEALTH FOR PATIENTS IN PRIMARY CARE

### 11.7.1 GP should be concerned with addressing occupational causes of ill health

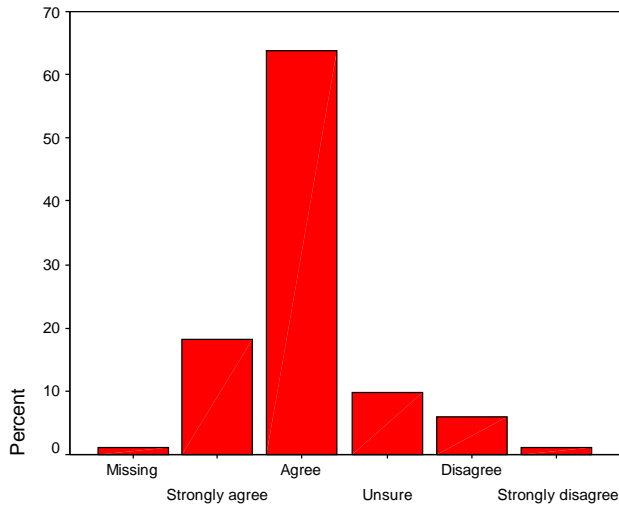


Chart 11.7.1 shows that most of the respondents (82.9%) agreed (or strongly agreed) that GPs should be concerned with addressing occupational causes of ill health.

### 11.7.2 I do not have time to explore occupational health issues in patient consultations

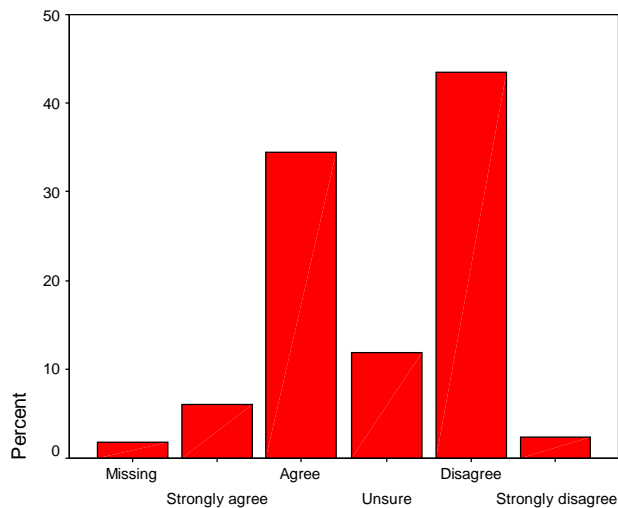


Chart 11.7.2 shows that there was roughly an even split between those respondents who did not have time to explore occupational health issues in patients consultations (strongly agree 6.2% and agree 35.1%), as those that did have time (44.3% disagree and 2.4% strongly disagree).

### 11.7.3 I feel competent to explore possible occupational health problems in patients

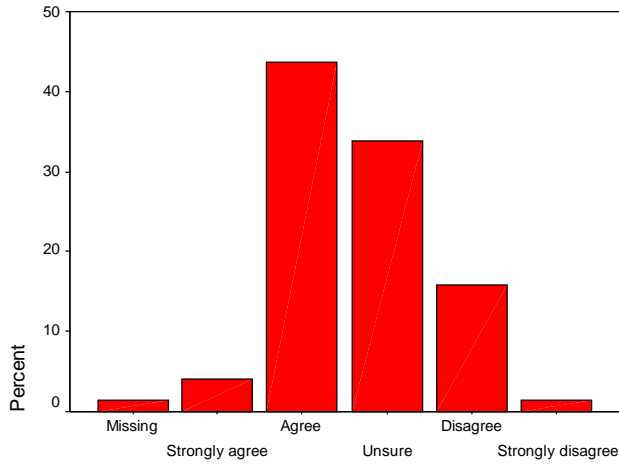


Chart 11.7.3 shows that roughly 50% (4.1% strongly agree and 44.2% agree) of respondents felt competent to explore occupational health problems in patients, whereas 34.2% were unsure, and 17.5% felt that they were not (1.4% strongly disagree and 16.1% disagree)

### 11.7.4 Further training would improve my ability to address occupational health issues for patients

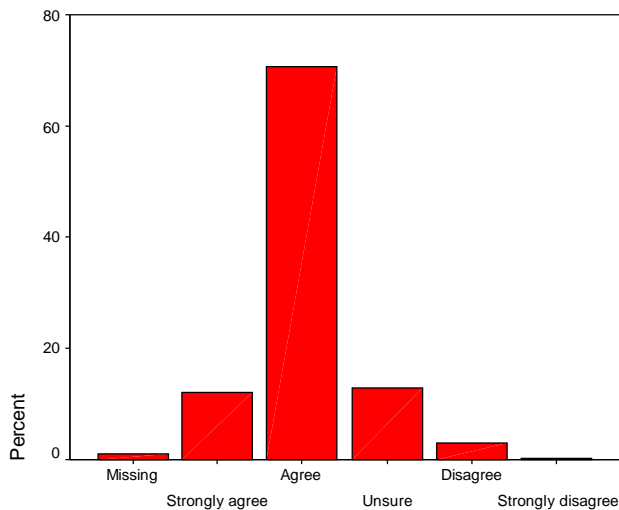


Chart 11.7.4 shows that over three quarters of respondents (12.3% strongly agreed and 71.3% agreed) felt that further training would improve their ability to address patients occupational health issues.

### 11.7.5 MED 3 sickness certification is a useful tool for communicating with patients employers

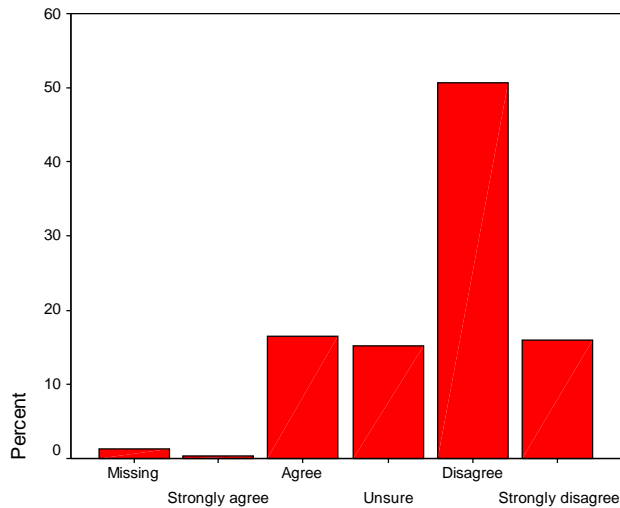


Chart 11.7.5 shows that over two thirds of respondents (51.4% disagree and 16.1% strongly disagree) thought that the MED 3 sickness certification was not a useful tool for communicating with patients employers.

### 11.7.6 MED 3 sickness certification should continue to be provided by GPs

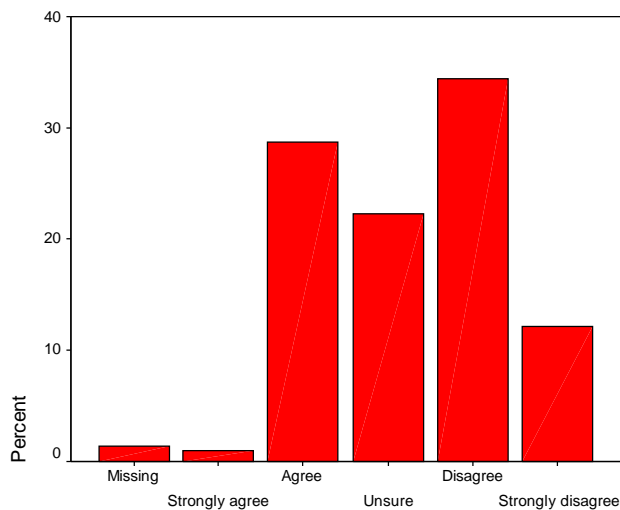


Chart 11.7.6 shows that nearly half of the respondents (34.9% disagree and 12.3% strongly disagree) thought that the MED 3 should not be provided by the GP, whereas approximately a third (29.1% agree and 1% strongly agree) thought that the MED 3 should be provided by the GP.

**11.7.7 Occupational health physicians are more concerned with reducing absenteeism than what is best for individuals**

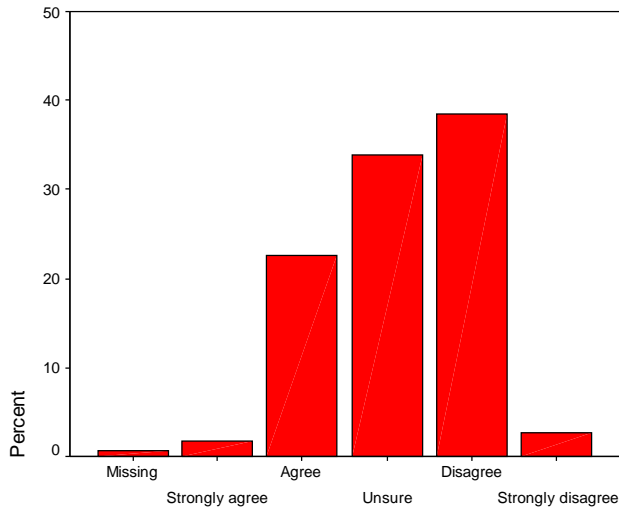


Chart 11.7.7 shows that approximately a third of respondents were unsure whether occupational health physicians were more concerned with reducing absenteeism than what is best for individuals, however over 40% disagreed with this.

**11.7.8 Doctor patient confidentiality prevents GPs communicating with the employer of patients**

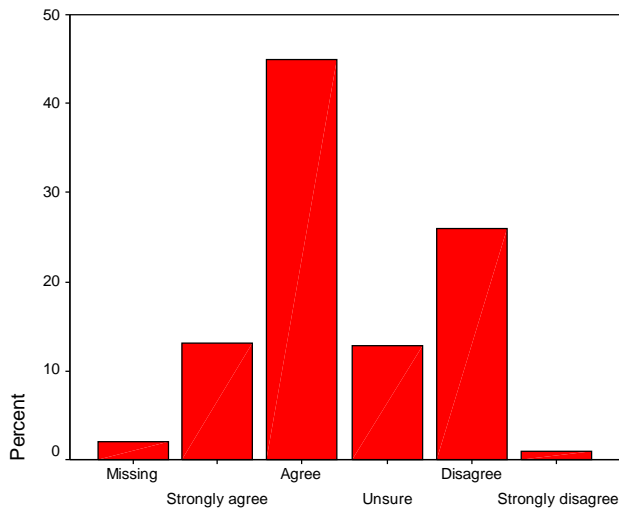


Chart 11.7.8 shows that the majority of respondents agreed (13.4% strongly agreed, 45.9% agreed) that doctor patient confidentiality prevents GPs communicating with the employer of patients.

### 11.7.9 I do not have sufficient knowledge to assess 'fitness to work'

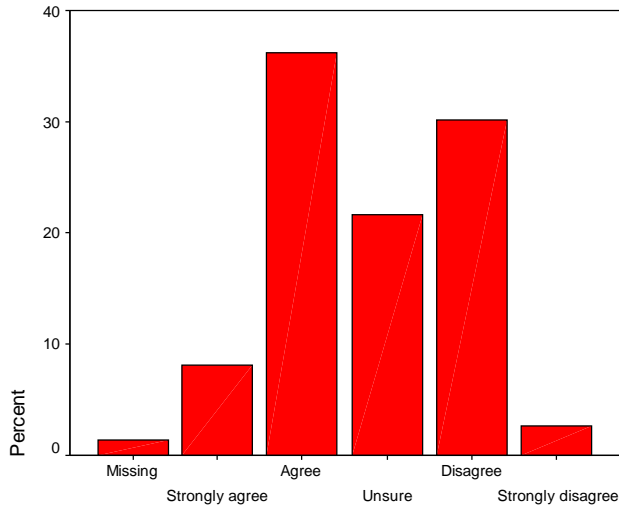


Chart 11.7.9 shows that there was a roughly equal split between those respondents who thought that they did not have sufficient knowledge to assess fitness to work (8.2% strongly agree, 36.6% agree) and those who thought that they did (2.7% strongly disagree, 30.5% disagree)

### 11.7.10 I tend to rely on the patients judgment regarding 'fitness to work'

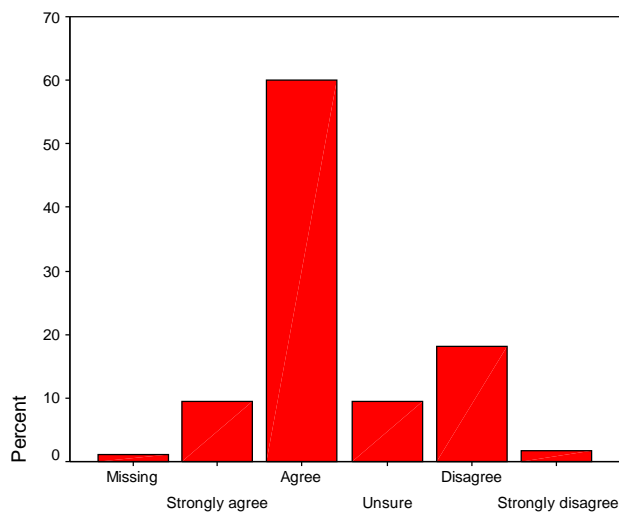


Chart 11.7.10 shows that the majority (9.6% strongly agree, 60.8% agree) of respondents rely on the patient's judgment regarding 'fitness to work'

**11.7.11 Long waiting lists for secondary referrals prevent patients from returning to work earlier**

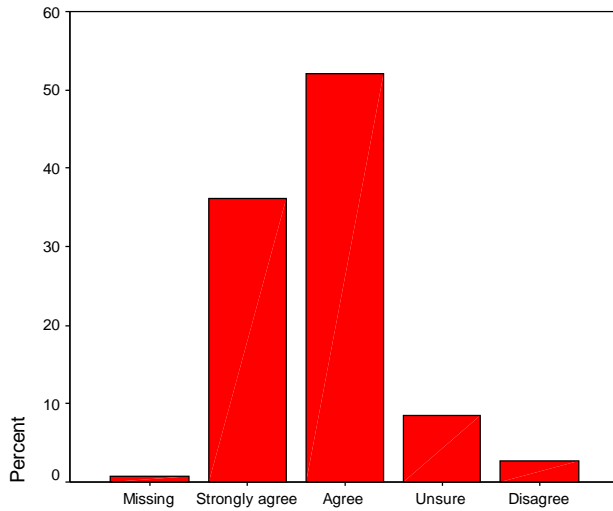


Chart 11.7.11 shows that the majority (36.4% strongly agree, 52.4% agree) of respondents agree that long waiting lists for secondary referrals prevent patients from returning to work earlier

**11.7.12 My workload has been increased by employers not accepting self certification**

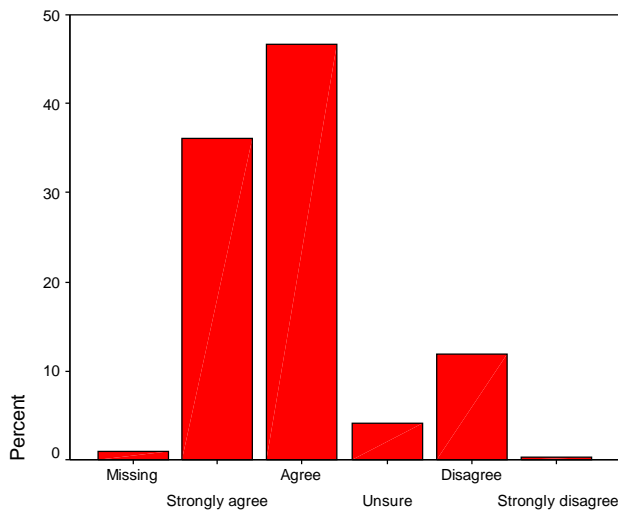


Chart 11.7.12 shows that the majority (36.5% strongly agree, 47.1% agree) of respondents agree that their workload has been increased by employers not accepting self certification

**11.7.13 GPs can only advise patients to speak to their employers about work related health problems**

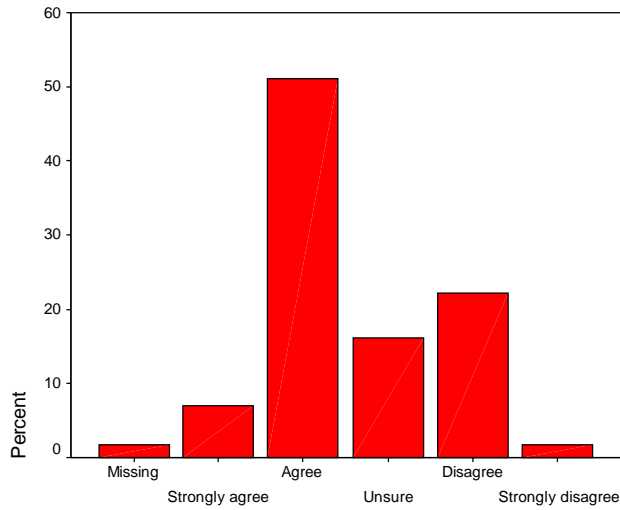


Chart 11.7.13 shows that the majority (7.2% strongly agree, 51.9% agree) of respondents agree that GPs can only advise patients to speak to their employers about work related health problems

**11.7.14 I am not aware of services to refer patients with occupational health problems**

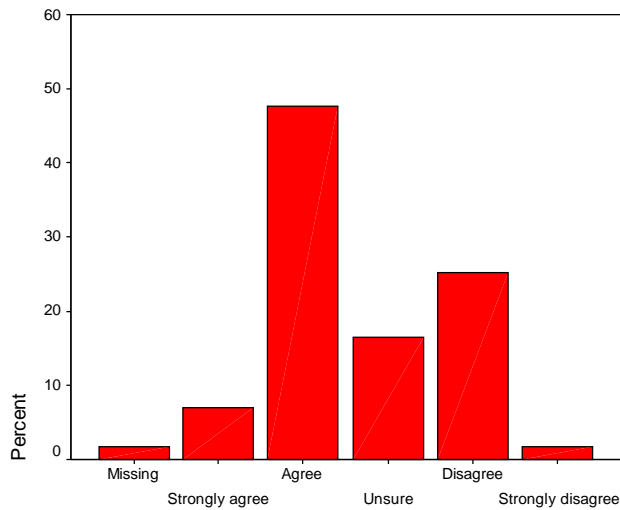


Chart 11.7.14 shows that the majority (7.2% strongly agree, 48.5% agree) of respondents are not aware of services to refer patients with occupational health problems

### 11.7.15 I am not aware of any local occupational health provision for GPs

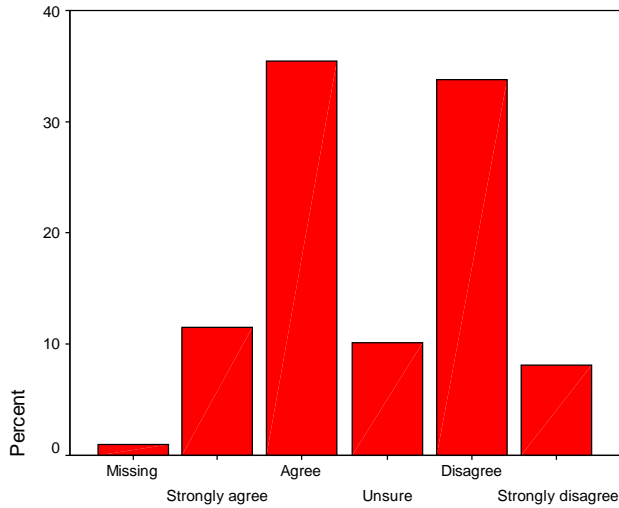


Chart 11.7.15 shows that there was a roughly equal split between those respondents who are not aware of local occupational health provision for GPs (11.6% strongly agree, 35.8% agree) and those who are (8.2% strongly disagree, 34.1% disagree).

### 11.7.16 Occupational health provision for GPs in my practice has improved in the past five years

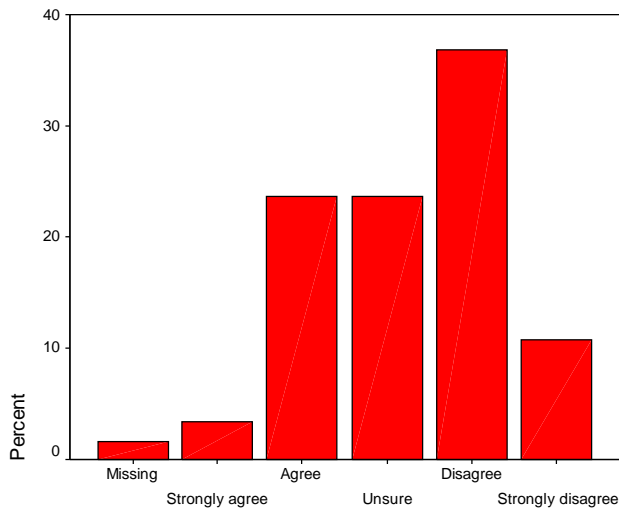


Chart 11.7.16 shows that approximately half of the respondents (11.0% strongly disagree, 37.5% disagree) thought that occupational health provision for GPs in their practice has not improved in the past five years.

### 11.7.17 There is a need for improved occupational health provision for GPs

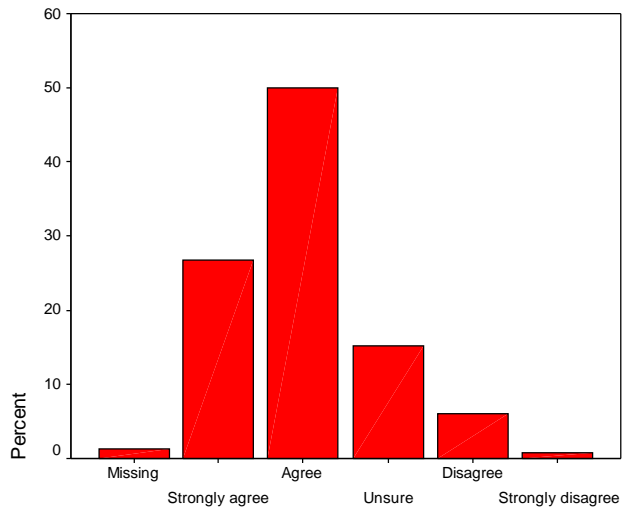


Chart 11.7.17 shows that the majority (27.1% strongly agree, 50.7% agree) of respondents feel that there is a need for improved occupational health provision for GPs

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