

## How do Dutch GPs address work-related problems? A focus group study

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### KEY MESSAGES

- Patients and society expect GPs to play a proactive role in work-related problems.
- Participants of this study indicate they need better cooperation with occupational physicians to help patients with medically unexplained symptoms to continue working.
- GPs need training to develop a more proactive approach to work-related problems.

### ABSTRACT

**Background:** In the Netherlands, there is a lack of knowledge about general practitioners' (GPs) perception of their role regarding patients' occupation and work related problems (WRP). As work and health are closely related, and patients expect help from their GPs in this area, a better understanding is needed of GPs' motivation to address WRP.

**Objectives:** To explore GPs' opinions on their role in the area of work and health.

**Methods:** This is a qualitative study using three focus groups with Dutch GPs from the catchment area of a hospital in the Southeast of the Netherlands. The group was heterogeneous in characteristics such as sex, age, and practice setting. Three focus groups were convened with 18 GPs. The moderator used an interview guide. Two researchers analysed verbatim transcripts using constant comparative analysis.

**Results:** We distinguished three items: (a) work context in a GP's integrated consultation style; (b) counselling about sick leave; (c) cooperation with occupational physicians (OPs). The participants are willing to address the topic and counsel about sick leave. They consider WRP in patients with medically unexplained symptoms (MUS) challenging. They tend to advise these patients to continue working as they think this will ultimately benefit them.

**Conclusion:** The participating GPs seemed well aware of the relation between work and health but need more knowledge, communication skills and better cooperation with occupational physicians to manage work-related problems.

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## Introduction

Working or not being able to work are important determinants for quality of life and mortality.[1,2] Work related problems (WRP) include health problems caused by work and health problems influencing patients' ability to work.

Thus, many health problems are work related.[3] Consequently, loss of productivity due to health problems is considerable. Medical professionals are expected to be competent to recognize this relation and play an

important role in the prevention and reduction of unnecessary loss of working days. In most countries, GPs have a central role in sickness certification but in the Netherlands, GPs do not complete sickness certificates. According to The Gatekeeper protocol, employers and employees share the responsibility for sick leave. If necessary, sickness certification is delegated to occupational physicians (OPs) or Occupational Health Services. This system has contributed to the reduction of long-term disability in the Netherlands.[4,5]

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Medical attention to work-related health issues is not merely about the reduction of absenteeism. Promotion of healthy working habits and working conditions and prevention of work-related diseases are considered to be tasks of OPs, but not all working patients have access to an OP.[6,7] GPs can act in an intermediary role if access to an OP is not readily available. GPs can advise patients with self-limiting diseases or chronic diseases how to continue working and thus support a healthy lifestyle, social participation and a sense of well-being.[1] Therefore, the Dutch College of General Practitioners (NHG) has started to pay more attention to work in its guidelines.[8] Moreover, in its 'core values,' the NHG explicitly stresses the importance of proactively exploring a possible work-relatedness of health problems during consultations.[9]

Still, there are several indications that Dutch GPs should pay more attention to the influence of occupation and working circumstances on the patient's complaints. For example, in a study of employees who were sick-listed for 12–20 weeks due to mental health problems, GPs discussed work conditions in only 28% of the cases.[10] Another study among sick-listed patients showed that they appreciate a more active role of their GP during episodes of sick leave.[11] Many GPs consider this task burdensome, and a study among Swedish GPs found that for some it was a reason to stop working as a GP.[12–14]

Because of the importance of work-related health issues and the demonstrated lack of attention for work of Dutch GPs, we conducted a focus group study with the following questions: what are the opinions of GPs concerning the importance of work for the understanding of presented health problems; what are their

experiences in giving attention to WRP, dealing with questions about sick leave and cooperating with OPs; and what do they think can be done to strengthen the GP's role in the area of WRP?

## Methods

### Design

We performed a focus group study with semi-structured interviews using a topic list among three groups of GPs working in the Southeast of the Netherlands. We used focus groups because these are particularly suited to understand shared attitudes in a group of professionals. Group interaction helps the participants to develop their thoughts about the topic.[15] According to Dutch law, qualitative research based on interviews of healthcare professionals does not require the approval of a medical ethics committee.

### Participants and procedure

The researchers invited all GPs in the catchment area of a local hospital to participate, offering a €50 gift voucher as an incentive. Initially, 20 out of approximately 100 GPs responded positively, and 18 did participate in one of the focus groups. The sampling strategy was pragmatic, resulting in a diverse group on the following characteristics: gender, age, years of experience, being a partner or a salaried GP, activities in occupational medicine, geographical location of the practice and socio-economic features of the patient population (Table 1).

Each focus group consisted of five to seven GPs. The research team informed the participants about the

**Table 1.** Characteristics of the participants of the focus groups.

GP Code (focus group)	Age	M/F	Training <sup>a</sup>	Experience <sup>b</sup>	FTE	Type of practice	Partner/ salaried	Situation of practice	KO (%)
1 (1)	58	M	N	29	1.00	SH	P	U	10.0
2 (1)	49	M	M	25	0.75	HC	P	U	50.0
3 (1)	50	F	L(B)	23	0.40	DUO	P	R	50.0
4 (1)	50	M	L(B)	23	1.00	DUO	P	R	10.0
5 (1)	49	M	M	20	0.75	HC	P	U	7.5
6 (2)	61	M	N	31	1.00	SH	P	R	95.0
7 (2)	47	M	M	4	1.00	GR	P	U	20.0
8 (2)	35	F	M	5	0.80	SH	P	U	10.0
9 (2)	37	F	M	8	0.60	HC	P	U	20.0
10 (2)	32	F	M	4	0.60	DUO	S	UV	50.0
11 (2)	56	M	N	23	1.00	GR	P	UV	30.0
12 (3)	57	F	N	29	0.60	GR	P	UV	60.0
13 (3)	34	F	N	3	0.90	GR	S	UV	60.0
14 (3)	53	M	N	21	0.90	HC	P	U	65.0
15 (3)	52	F	U	20	1.00	GR	P	UV	20.0
16 (3)	37	F	M	6	0.80	GR	P	R	60.0
17 (3)	30	F	M	1	0.90	DUO	S	UV	5.0
18 (3)	53	M	N	22	0.80	GR	P	U	60.0

<sup>a</sup>Trained as GP in the medical school of: N: Nijmegen; M: Maastricht; L(B): Leuven (Belgium); U: Utrecht.

<sup>b</sup>Years of experience working as a GP at the time of focus group.

FTE: full-time equivalent working as GP; SH: single-handed; DUO: duo; GR: group practice; HC: health centre; P: partner; S: salaried GP; U: urban; UV: urbanized village; R: rural; KO: percentage of patients of whom GP thinks he knows the occupation.

aim of the focus groups and obtained informed consent. The participants completed a short questionnaire on baseline characteristics including a question on the estimated percentage of patients of whom the GPs thought they knew the occupation.

The participants and two researchers (PL, CK) work as GPs in the same area. The research assistant collected the informed consent forms and questionnaires, and made notes and audiotapes of the discussions. The second author (PL) acted as moderator, the first author (CK) acted as observer.

A topic list based on literature and expert opinion structured the discussions. The moderator was familiar with the subject, practicing as a GP for more than 30 years. The focus group discussions were recorded on audiotape, transcribed verbatim by an experienced research assistant and inserted in ATLAS.ti (version 6.1), a software programme designed for the analysis of qualitative data.<sup>[16]</sup>

### Analysis

Two researchers (CK, LS) analysed the transcripts of the sessions. They first independently coded the text. In discussions, they reached consensus about the codes. According to the method of constant comparative analysis, these codes were compared with the text of the transcripts during an iterative process and accordingly adjusted and refined.<sup>[17]</sup> Following the initial coding process the two researchers discussed the findings with a third researcher (PL) and combined codes into larger categories.

### Results

We distinguished three themes: (a) work as an element of an integrated consultation style; (b) work as a component of sick leave management; and (c) cooperation between GPs and OPs.

#### *Work as an element of an integrated consultation style (Box 1)*

There appeared to be a broad consensus among the GPs in the focus groups about the importance of work and WRP and that paying attention to them is an ingredient of good patient care. They said they pay attention to the subject and mention a variety of reasons to do so: it helps them know and understand the patient and his/her context of which work is an important element. Knowledge of work also facilitates a better analysis of the patient's health problem. Some

#### **Box 1.** Quotes illustrating theme 1: 'Work as an element of an integrated consultation style'.

- Q1.1 'In this situation I evidently try to take a patient-centred perspective, to discover where he finds his support, very often they find support in their job: as being able to continue to work, they feel that not all is lost.' (GP4, male, 50 years)
- Q1.2 'How others react, both at home and on the job, to understand what factors enable symptoms and what causes these symptoms.' (GP8, female, 35 years)
- Q1.3 'In some cases, I already know that it is a sensitive subject and that it will be very time-consuming to talk about it. So, for example, if I am already running behind on my schedule, I will sometimes just let it be, I will raise the subject another time.' (GP10, female, 32 years)
- Q1.4 'First I try to get the patient to become aware of what his symptoms mean to him, first exploring his symptoms in a broader sense. Thus not focusing on his symptoms, that his back hurts, the pain in his back, but how do these symptoms trouble him.' (GP6, male, 61 years)

participants also mentioned attention for the combination of work and housekeeping. Reasons for proactively exploring the patient's work context were very diverse. One GP explores the context of a patient diagnosed with cancer to see where he finds support (Q1.1). Another GP asks for the reactions of a patient's colleagues to understand how these may influence the symptoms (Q1.2).

However, several GPs stated that they do not address a patient's occupation consistently during every consultation: depending on how a consultation evolves, work-related issues will or will not be addressed. Time constraints (Q1.3) or the GP's fear that the patient may want a judgment about being able to work are reasons not to address work issues. It appeared that participants often do not record occupation in the electronic medical record (EMR) and they indicated that the software programme is not well suited for this information.

Some GPs indicated that they explicitly question patients with medically unexplained symptoms (MUS) about their work in relation to these complaints in order to create awareness of the relation between their complaints and psychosocial context (Q1.4).

#### *Work as a component of sick leave management (Box 2)*

GPs in this study were reluctant to offer advice on fitness for work and were comfortable to do so only in cases they considered serious or where the patient had demonstrable pathology. Some GPs avoid the subject because they fear the patient might use the discussion as an excuse for sick leave (Q2.1). Other participants said that they prefer to leave the decision

about fitness to work to the patient or the OP (Q2.2). Some do give advice but at the same time make it clear that the decision is not up to them (Q2.3). The decision to discuss sick leave or to advise continuing with work is strongly influenced by the somatic, psychological or functional nature of the complaints. When the complaints have a clear biomedical explanation, or when the psychosocial problems are severe, the advice to take a sick leave is given more readily. When, according to the GPs, the continuation of work could be harmful to the patient's health, taking sick leave is also advised. In these instances, GPs tend to take the role of advocate or mediator for the patient (Q2.4). GPs in the focus groups take into consideration whether patients are frequently consulting for minor problems or – alternatively – consult infrequently (Q2.5). Work modification can offer possibilities to remain active in one's job. Some participants mentioned this as an attractive alternative to sick leave, and one gave an example of how he might suggest to a patient to ask for job modification (Q2.6).

In patients with mental disorders, the participants let the advice to take sick leave depend on the way the problem might interfere with the patient's ability to perform (safely) in his job (Q2.7). For patients with functional complaints, GPs' opinions showed more variation, ranging from explicitly encouraging a patient to keep working to withholding any remark about going to work. While suffering in patients with serious somatic problems seems to elicit sympathy in the GP and

advice in the direction of taking sick leave, the GPs find it more difficult to connect with the suffering of patients with functional syndromes, and here they tend to advise to try to resume working (Q2.8, Q2.9).

The GPs in the focus groups appeared to be more willing to give advice to start working again than to go on sick leave. The reasons were personal norms concerning work, role perception, and legal and practical considerations. In the present situation, most participants seemed happy with the division of tasks between OP and GP. In general, the participants did not like the idea of having to be responsible for sick leave certification.

### Cooperation between GPs and OPs (Box 3)

The GPs indicated that they have little cooperation with OPs. Most do have occasional contacts with an OP. The participants who initiate contact with an OP valued the information from OPs. They mentioned as drawbacks of the present system the fact that people working in small companies have no easy access to an OP; not being informed or contacted by the OP; and difficult access to the OP when initiating contact themselves. They debated whether it is the GP's or OP's responsibility to contact the other. One participant expressed her need for a sense of alignment in WRP (Q3.1). Another participant expressed his frustration about the fact that OPs appear not to value the exchange of information between them (Q3.2). The participants considered themselves as advocates of their patients whereas

#### Box 2. Quotes illustrating theme 2: 'Work as a component of sick leave management'.

- Q2.1 'When patients explicitly ask whether they can work, I become a bit anxious and feel a bit attacked. Could be that I'd rather not bring up the subject of work.' (GP4, male, 50 years)
- Q2.2 'I do not give any statement concerning the ability to work or not, unless obvious. I usually refer to the occupational physician; they are the ones to judge whether a patient can work or not.' (GP7, male, 47 years)
- Q2.3 'Then I add that I am not in the position to judge whether someone can work or not, that it is the occupational physician's responsibility, and actually, I am kind of glad that I don't have to judge. But still, I do tend to give my opinion, that I think it would not be a good idea (to go to work).' (GP10, female, 32 years)
- Q2.4 'I think of this man who never visits the doctor, who now has a neuropathy and atrophy in both his hands, who has worked for twenty years operating a crane with those joysticks, all day moving cars from here to there, here in the press and there in the shear, and this man, who never missed a day of work, now he has this atrophy and cannot really perform his job anymore. His company says this person just has to work, he has to come in, that's it. In this case, I take a position, yes: "I think you are no longer able to do that job."' (GP1, male, 58 years)
- Q2.5 'Someone, who visits our clinic once every five, six years and comes to see me for back pain, I will easily say: "take some days off, have some rest and then try going back to work." Someone who I have seen 25 times with (a specific) pain in the back (with a normal function), I will say: "You are still able to do some work," so it depends on the person.' (GP6, male, 61 years)
- Q2.6 "... if it can be arranged in your company that you do some other work," I always try to look for that kind of possibilities so that they can stay active. But if I am convinced that the pressure or limitations make working impossible I will say that too.' (GP1, male, 58 years)
- Q2.7 'People who just decompensate mentally, with depression, who can be a threat when driving or working with machines, or someone to whom I prescribe an antidepressant, should not operate a crane, or that sort of thing.' (GP7, male, 47 years)
- Q2.8 'Fibromyalgia is kind of an allergy for the doctor, if I am really honest I think I would tend to stimulate the patient to continue doing what he can, just continue. This is, for me, a difficult case.' (GP13, female, 34 years)
- Q2.9 'The group of patients I find the most difficult, are patients with so-called functional symptoms, people with a headache, pain in the back is often functional as well, as they don't all have herniated discs or whatever. . . Then I find it more challenging.' (GP12, female, 57 years)

**Box 3.** Quotes illustrating theme 3: 'Cooperation between GPs and OPs'.

- Q3.1 'You need the feeling that you are heading in the same direction. When I did call an OP the other day, I got a thoroughly different version of the story than what the patient had told me. If you want to help the patient—and that is of course what you both want at the end of the day—I think you need this common goal. I think that contributes to the healing process and also to the patient's ability to work, of course, the reintegration into working life.' (GP10, female, 32 years)
- Q3.2 'Give me a call for heaven's sake or write me a note, and it happens very seldom. Maybe it is because of the population, I don't know, (but it is) hardly ever that we are asked to give information or get a call, not even once a month shall we say.' (GP5, male, 49 years)
- Q3.3 'I often get back from the patients that the OP acts for the employer and less for them and what they say gets back to their boss. . . Yes.' (GP7, male, 47 years)

they think the OP has to serve two masters, i.e. the company and the patient, and does not always prioritize the interest of the patient. Many GPs expressed reluctance to initiate contact with OPs (Q3.3).

To facilitate cooperation, some GPs mentioned that OPs should initiate telephone contact with the GP in patients with complex problems or patients with conflicts concerning their job. In less complex cases, GPs would like to receive a concise report from the OP in a timely manner.

## Discussion

### Main findings

GPs in our study agree that it is important to pay attention to work during consultations, partly because it fits with their ambition to use an integrative or holistic work style and partly because of the importance of discussing sick leave. However, their opinions are especially diverse concerning the issue of sick leave. Most GPs in this study say that they explicitly give advice to take sick leave to patients with serious somatic problems and patients with depression, whereas they do not advise sick leave to patients with medically unexplained symptoms, however serious. In the former situation, these GPs adopt the role of advocate. Many participants are not happy with a role in deciding about sick leave or are ambivalent about discussing the topic. A minority of the GPs say that they refrain from any advice regarding sick leave as they consider this the responsibility of OPs. Participants reported that they lacked the knowledge to advise patients specifically concerning their work environment. The EMR in this

present form was mentioned as a hindrance with respect to the recording of occupation. Most GPs in this study value the specific expertise of OPs, but say they experience a lack of access and communication. One of the difficulties here is a lack of confidence in the OP's neutrality, based on the assumption that the OP serves two masters.

### Strengths and limitations

Focus groups are well suited to demonstrate the variation of opinions among professionals. However, a disadvantage of these studies is that they reflect what people say they think and do. When GPs say that they do pay attention to work-related issues, they possibly promote their profession's ideology instead of giving a clear insight into what they do. A more valid method for assessing what is happening would be direct observation.

A strong point of our study is the procedure with two researchers independently coding the transcripts.

Limitations are the small study sample and the selection of participants: although the pragmatic sampling strategy brought together a varied group of GPs, the sampling strategy was not strictly purposive. The lack of young male GPs might be the consequence of this. Moreover, the GPs who participated may represent a group of GPs who are relatively aware of WRP. A final limitation is that we did not use a cyclical analysis. The fact that the moderator was working as a GP in the same area may have led to some extent to politically correct answering. Alternatively, it facilitated a safe atmosphere and open dialogue among participants with an exchange of many different points of view.

### Addressing occupation and work related problems

Paying attention to the occupation and working environment of patients is considered essential for the understanding of illness. Recent research demonstrated the effect that being out of the labour force has on mortality.[2] The core values of Dutch GPs are very clear about the importance of work in the life of patients and explicitly state that this warrants structural attention from GPs.[9] The fact that Dutch GPs have no formal task in the certification of sick leave seemed to explain the lack of attention of Dutch GPs for sickness absence and work in general. However, in countries where GPs do have a role in certification, GPs also experience problems fulfilling this challenging procedural, relational, organizational and political role.[18] In

the UK, GPs have not been found to be very effective in reducing sick leave, in spite of training programs that were instigated to help them improve their performance.[19,20] Nor do they consequently record occupational details in their EMR.[21] The reluctance of GPs on advising about sick leave might be explained by the finding that ‘GPs put far more weight on the preferences and needs of their patients than on the requirements of the organizations that employ their patients’.[22] General practitioners indicate that proximity and longevity of relationships between them and their patients, the ideology of holistic care and the wish to be an advocate for their patients are the foundations of this approach.[22] The results of our study seem to replicate this reluctance and its foundations. This form of personal care can be hindered by the organization of the health system which influences the relationship and trust between doctors and patients.[23] Dutch GPs rightly value their position of trust, and they seem to perceive a role in sickness certification as one which might compromise this relationship. Not having this role might make any advice to the patient to resume working less tainted by conflicting roles and, therefore, paradoxically even more effective.

### **Collaboration between GPs and occupational physicians**

The other main issue we identified in our study – difficulties in the collaboration with OPs – has received attention for many years. In 2009, a paper promoted joint training to improve trust and cooperation between GPs and OPs, enabling them to provide better care for workers.[24] The lack of confidence in OPs of GPs seems still present among the participants of this study and it is explained by their opinion that OPs prioritize the interest of employers. Also, the GPs who took part in this study admitted having a lack of knowledge about occupational health. GPs value communication with OPs by a brief note.[25] Our study additionally identified the limited access of GPs to OPs as an issue.

### **Implications for practice**

Work-related problems are highly prevalent in primary care and can have a high impact on patients’ well-being, years before they go on to claim benefit.[26] The issue of work in relation to disease is, therefore, important and should be routinely addressed by GPs during their consultations.[3] Patients with MUS or patients who frequently consult with what appear

to be minor problems deserve special attention, as the consequences on their workability can be very detrimental for all stakeholders. Attention for the working context fits well within the prevailing concept of patient-centred primary care.[28] However, although GPs are willing to pay attention to the topic, they experience difficulties in discussing sick leave and difficulties in the cooperation with OPs. Moreover, Dutch GP guidelines often do not mention information about ‘work’ in general or about arrangements to promote reintegration, like work modification.[6] Therefore, guidelines should be adapted to help GPs with these tasks and the EMR may need to be provided with applications that make it easier to record occupational information. Advice concerning work should also be well documented in the EMR, to prevent patients receiving conflicting advice when they have access to more GPs.[21]

However, if GPs are expected to better understand WRP and give targeted advice they need more knowledge and communication skills and they need to be convinced that this will benefit their patients. Therefore, training tailored to meet the specific challenges of the health system needs to be developed.[18] In the UK, training was helpful in changing GPs’ attitudes towards using the Fit Note, but so far, not many GPs have attended such training.[19,23] As the subject tends to rank low on the list of doctors’ preferences, motivation of GPs is a challenge. Attention for WRP should be presented as an essential element of GP care and as an opportunity to apply all elements of person-centred medicine.[8,27]

### **Conclusion**

In this study, GPs consider attention to work-related problems important in the light of patient-centred care, but they differ in how they advise on sick leave. In addition, GPs sometimes lack knowledge about work-related problems. Finally, they wish for a better cooperation with OPs.

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### **Declaration of interest**

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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