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EDUCATION

Teaching general practitioners and occupational physicians to cooperate: Joint training to provide better care for European workers

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What is already known?

GPs and occupational physicians often operate in divided worlds. They seldom cooperate, risking negative effects for their common patients/workers. Better training can be a solution, but good practices are rare.

What this study adds

A Dutch example of overcoming the long-lasting divisions between both medical professions—resulting in common training programmes—can be helpful, particularly regarding recent developments such as an increase in occupational health services in Europe, more health problems expected within an ageing workforce, and new initiatives by Wonca and WHO.

In Europe, sick workers usually contact their GP for treatment and certification. Increasingly, however, they can also visit an occupational physician (OP); the EU 1989 Directive increased occupational health services in Europe, up to 80–100% coverage for employees (France, Belgium, Slovenia, Finland, the Netherlands) (1). This development requires coordination between both physicians, particularly since more health problems are expected among the European workforce—the pillar of our prosperity—in terms of ageing, more (chronic) lifestyle-related diseases, higher retirement ages, and more rigid disability benefit criteria. However, coordination is often lacking (2,3), as illustrated by Dutch research (4,5), in which rare contact as well as GPs mistrusting OPs and often having a "blind spot" for work-related illness were reported (usual explanation: Dutch GPs do not have to certify sickness absence) (6). This situation can lead to inadequate diagnosis and treatment, contradictory advice, and unnecessary (and long) sick leave. Most physicians involved, however, want better cooperation—to improve insight, coordination, and rehabilitation—clearly indicating obstacles and prerequisites (4) (Table I).

Based on these research outcomes, Dutch GP and OP associations overcame long-lasting barriers by making a joint improvement agenda (7) for developing common views, guidelines, cooperation experiments, and training programmes. The government rewarded this by assigning nine GP and OP training-and-research institutes[1] to make joint postgraduate and CME training programmes for better cooperation, including raised GP awareness of work-related illness.

The project—supervised by representatives of employers and employees, the government, patients, and the medical associations involved—was relatively

[1]Four GP training institutes, the Dutch College of GPs, TNO Work & Employment, Free University Amsterdam, OP training institute Nijmegen University, Dutch School of Public & Occupational Health.

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Table I. Important obstacles to and prerequisites for GP–OP cooperation.

	GPs *n*=243	OPs *n*=232
Important obstacles, according to % of GPs/OPs:		
1. GPs do not know what OPs will do with medical information derived from GPs	58%	34%
2. GPs think OPs serve employers more than employees	48%	44%
3. GPs do not know what to expect from OPs	39%	54%
4. GPs have too little knowledge of occupational health and relevant legislation	34%	57%
5. One does not know the other physician personally	29%	22%
6. No guidelines about GP--OP cooperation are available	28%	37%
7. GPs do not take into account their patients' jobs	—	52%
8. GPs do not realize unnecessary sick leave can harm patients	—	49%
Important prerequisites, according to % of GPs/OPs:		
1. A clear OP mission: "Protect and improve workers' health!"	79%	72%
2. OPs must guarantee that medical information derived from GPs will not be sent to others without informed consent	79%	65%
3. To guarantee the OP's professional independency	76%	86%
4. OPs must clarify for GPs what they can really do for their patients	63%	65%
5. Guidelines on when cooperation is useful and who is responsible for which task	62%	68%
6. Using the same conceptual framework	57%	72%
7. OPs must profile themselves more as medical specialists in the field of work and health	48%	84%

self-steering. Twice a year, institute representatives visited a partner's meeting to discuss project progress, after first appointing a project management team, defining five training packages—one postgraduate programme and four CME programmes—and forming five development teams to make them, each comprising one GP, one OP, and other professionals.

Based on a training programme inventory confirming the research results mentioned above (4,5), a 4-day postgraduate vocational training programme was developed, including training in psychosocial aspects such as mutual trust. The programme was organized as follows: day 1, discussing the "other profession" separately, identifying cooperation obstacles; day 2, joint discussion about day 1, bidisciplinary groups solving practical problems, assignments for day 3; day 3: visiting the "other profession's" practice; day 4: feedback on day 3.

A trainee assessment before and after the course, and after 3 and 6 months showed: increased knowledge of information exchange guidelines; GPs advising more patients to contact OPs; OPs reporting more contact with GPs; and OPs giving more clients' notes to GPs. Some effects appeared or disappeared over the course of the assessment period. Personal contact promoted behaviour changes, based on increased mutual trust, helping to overcome mutual prejudices (8).

Also four CME programmes were developed. Within a 4–6-hour framework, cooperation was elaborated on regarding chronic diseases, mental and musculoskeletal disorders, and respiratory complaints: What can OPs and GPs do themselves? When should they refer to or consult each other, to coordinate diagnosis and treatment, in order to avoid giving contradictory advice?

Before being put into practice, eight independent GPs and OPs, each having taught cooperation, assessed these four programmes as being positive regarding "working methods", "organization", and "supporting materials", and proposed improvements concerning "learning objectives" and "content".

Discussion

Strengths

- Focus on frequent diseases and behaviour change
- Assessment before implementation (CME)
- Positive short-term effects
- Support from medical organizations

Limitations

- Long-term effects unknown
- Changing behaviour takes time
- Insufficient central/regional implementation steering

International relevancy and comparison

Insufficient cooperation, confusion about GP and OP roles, nor a GP "blind spot" for work-related illness are "typically Dutch" (2,9,10,11). International GP and OP organizations recently formed a common working group[2] to stimulate work-related

[2]Wonca-ICOH (International Commission on Occupational Health) working group, founded 10 November 2007, in Dubrovnik (see annual report 2007 by Prof. Svab, Wonca General Counsel Meeting, September 2008).

collaboration, while the World Health Organization (WHO) recently published a new strategy on workers' health (12), to incorporate occupational healthcare elements into primary care, which also requires GP–OP cooperation.

Traditionally, OPs try to influence working practice, but GPs also have enormous influence during treatment and recovery, assessing fitness for work and facilitating return to work, "the ultimate coordination goal and part of many patients' complete recovery", as a BMJ editorial stated, mentioning evidence "that primary care doctors, participating in minimising their patients' disability, achieve better health outcome and greater patient satisfaction" (2). Recent research confirms this potential GP role (13,14).

Therefore, in the interest of the patients involved, training in cooperation is needed[3]. Surprisingly, however, we only found one comparable initiative (15). Dutch experiences can therefore be useful.

Implementation

The medical associations involved offered their members a booklet on cooperation, including the CME modules on CD-ROM. The programmes were introduced to regional GP and OP educational bodies, while a trainers' pool was formed. Several medical faculties adopted the postgraduate programme. Finally, the Royal Medical Association incorporated all programmes into its Action Plan, which has led to curriculum adaptation.

Changing attitudes and creating mutual trust take time (16,17). Further implementation is therefore needed in addition to other initiatives to improve GP–OP cooperation, such as common guidelines, regional meetings, best practices, and opinion leaders' support. Moreover, more European comparative and effect research is needed, because better cooperation does not always have positive outcomes (18).

Conclusion

Given widespread insufficient GP–OP cooperation and an ageing European workforce, it is hoped that Dutch training and research institutes, overcoming long-lasting barriers, have developed joint training programmes with positive effects.

[3]See also the UK consensus statement on better cooperation (2).

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