

The interaction between general practitioners and occupational health professionals in relation to rehabilitation for work: a Delphi study

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Background	Anecdotally, communication between general practitioners (GPs) and occupational health professionals is poor and acts as a barrier to successful rehabilitation for work. It is not known how widely this view is held by the many stakeholders in rehabilitation for work, or how important the observation is in its effect.
Methods	A Delphi study was conducted by initial semi-structured telephone interview, followed by a three-round collation and feedback of opinion by e-mail. The 25 participants were identified by suggestion within the study process for their position as key informants within a wide range of stakeholders.
Results	The process generated a consensus statement which identifies the extremely important nature of rehabilitation for work, the crucial role by GPs, the central role of occupational health professionals in case management and the barrier represented by the often very poor communication between them.
Conclusion	The way forward is to improve communication by mutual education and understanding and a team approach to rehabilitation strategy. This may be facilitated by the GPs who work in occupational health and disability assessment and the involvement of other health professionals to great benefit for all stakeholders.
Key words	General practitioners; occupational health professionals; poor communication; rehabilitation for work.
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Introduction

Conversations between occupational health (OH) professionals about the barriers to successful rehabilitation for work will usually have poor communication with general practitioners (GPs) and inappropriately long sick notes high up the list. The subject has been an issue for occupational physicians for as long as an elder statesman of the speciality can remember [1]. Despite the frequency of this observation, there is little written about it. It is not known whether there is acknowledgement of the situation

by other groups, or whether it is considered to be of any consequence. It was following one such conversation at a meeting of the Society of Occupational Medicine (SOM) that the author was asked to undertake a piece of work to clarify this for the Society.

Rehabilitation for work (vocational rehabilitation) is currently being given a high profile by many different stakeholders [2]. In order to obtain the views of key informants from a number of stakeholders, a modified Delphi study was undertaken. The aim was to reach consensus as to the shared understanding of the importance of rehabilitation and the effect of the respective roles and interaction between GPs and OH professionals, the significance of this relationship and any actions required.

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Methods

The Delphi technique

Much has been written about the Delphi technique [3–7]. Named after the Oracle at Delphi, the priestess of Greek mythology who made prophecies about the future, it was developed by the Rand Corporation in America in the early 1950s, to predict the potential effects of technology and of nuclear war on society. It is a multi-stage iterative process, where opinion is sought from a group of ‘experts’ who are remote from each other and anonymous. The opinion is collated by a researcher and fed back to the ‘experts’ for their comment in a series of two, three or four rounds. At each stage, the information is refined by the ‘experts’ until (it is hoped) consensus is reached. It has been extensively used in nursing and social science research, but there are also a number of examples of its use in occupational medicine [8,9]. Indeed, one of the participants of this study (E.M.) has published a Delphi study on training in occupational medicine [10].

Comment may be made about the value of such qualitative research in an era of evidence-based medicine and guidelines. However, consensus methods such as the Delphi technique are recognized as being important sources of information in complex, broad or uncertain problems where a body of evidence does not already exist [7]. Unfortunately, this is not an uncommon scenario, even in modern medicine. In the UK, the NHS Research and Development Health Technology Assessment programme aims to ensure that high quality research information is produced in the most efficient and effective way. It has reviewed the consensus methods increasingly being used to develop clinical guidelines defining key aspects of the quality of health care and found the Delphi method to be valid for this purpose [11].

One of the characteristics of the technique is that since its original development it has been modified in many ways. Most of its principles have been challenged or amended. This modification differs from the original in three main ways. First, the vast majority of studies have involved the use of written questionnaires which are sent by post, whereas this study used e-mail and only one other study was identified which has used e-mail [12], with its value of immediate response (and the choice to copy the response to all participants). Secondly, one of the key principles is that of anonymity, used to prevent individual dominance. This has previously been challenged as restricting interaction [3]. In this study, the initial interviews and the first round of feedback were conducted anonymously. For the subsequent two rounds, the identities of the participants were known to all involved. This was considered to be of value to the developing debate and also to utilize one of the other

features of the Delphi study—the ability to ‘build bridges’ [13]. The third difference was the omission of the need to rank a series of statements. This was not considered to add to the process.

The researcher

As well as being the author, I was also the researcher for the study. As a full-time occupational physician with a particular interest in rehabilitation for work, I also have the experience of 12 years as a principal in general practice.

The ‘experts’

The concept and definition of ‘expert’ have also been questioned and amended in different modifications of the technique. As well as someone being considered a professional expert, it can also refer to a participant who is ‘informed’ [5]. The intention in this study was to identify key informants from a range of stakeholders. As the topics of the study, GPs and OH professionals needed to be involved. The other stakeholders were recruited as the study progressed. The named participants were actually identified by the eighth and final question of the original interview—‘who else should I approach for a view on this subject?’ This process identified 26 potential participants, all of whom were contacted by telephone.

The process

The study was carried out over a 4 month period from July to October 2002. The initial phase was a series of semi-structured telephone interviews, with the researcher documenting the responses to eight open questions, designed by the researcher to address the aims of the study (Table 1).

The answers were collated by myself as the researcher and condensed to form a draft statement on the subject. This statement was sent to the (anonymous) participants for comment. Following incorporation of the feedback from the participants, a revised version of the statement was prepared and disseminated to the participants. At this stage (and with the consent of all participants), a participant list was attached. There then followed a third and final round.

Table 1. The questions used in the initial semi-structured interview

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| 1. | How important an issue is rehabilitation for work? |
| 2. | What part do you feel GPs play in this currently? |
| 3. | What part do you feel OH professionals play in this currently? |
| 4. | What role do you think GPs ought to have? |
| 5. | What role do you think OH professionals ought to have? |
| 6. | How well do you feel GPs and OH professionals currently interact in relation to rehabilitation for work? |
| 7. | How would they best work together on this? |
| 8. | Who else should I approach for a view on this subject? |

Results

Of the 26 potential subjects identified and approached, 25 agreed to participate. The one who declined felt that she did not have a particular view on the subject. The 25 participants all continued through the initial interview and three rounds of statement refinement. They were encouraged to do so by a series of e-mail and telephone reminders. It must be stressed that because of the spontaneous nature and short time-scale of the study, the views expressed must be seen as those of the participants and not necessarily those of their organizations. In addition, because of the complex nature of the subject, not all participants could be expected to be conversant with all aspects of the statement. The roles of the participants are believed to be correct as of October 2002.

The initial telephone interviews lasted between 10 and 40 min. Effort was made to ensure that participants were not guided in any way to suggest that a particular answer was expected and no comment was made about the level of detail required to answer the open questions. The comment was made, particularly regarding question 1, that a five-point scale of importance could have been used to determine the strength of opinion. This proved not to be of consequence, since all 25 participants answered in the superlative. The commonest expression used was 'very' or 'very, very important'. Other words often used were 'extremely', 'essential' and 'crucial'. In addition, although some gave a one-word answer to the question, the open nature of the question gave others an opportunity for a veritable discourse of the value of rehabilitation to the individual, to their employer and to society as a whole—ideas which were incorporated into the statement.

Regarding the current roles of GPs and OH professionals (questions 2 and 3), there was general agreement that in terms of rehabilitation there were positive and negative comments to make. These were regarding the values of the respective roles compared with the potential delaying or inhibiting effects each could have. The relative emphasis placed on these varied between participants. In terms of the roles which GPs and OH professionals ought to have (questions 4 and 5), there was again general agreement that GPs need to be more aware of just how important their role is and how important work is to the health of their patients. For OH professionals, it was highlighted that best practice needs to be developed and spread with the intention that they become a more central and proactive part of the process. Three people commented that they had insufficient experience to comment on the current level of interaction (question 6), but the remainder agreed that, generally, communication between the two groups is poor. A number of constructive suggestions were made as to how this interaction could be

improved, mainly around improved understanding of the respective roles, constraints and levels of influence.

The initial statement presented by e-mail to the group represented a collation of the expressed views and was considerably shorter than the final version. The majority of comments and proposed amendments were fed back direct to the researcher alone by e-mail. Some chose to copy the response e-mail to all participants. This prompted some enlightening debates between rounds and certainly served to develop and refine the statement further. One such example was the degree to which we should refer to the paucity of communication between GPs and OH professionals—all agreed that it was poor, but some felt it was very poor. Others felt that even if this is actually the case, it was important that the statement was not so extreme as to give the impression that there is no way to alter the situation. The compromise reached was that communication 'is often very poor'.

As the statement developed from round to round, more detail was added, particularly regarding the constraints and difficulties faced by GPs and also more about the role which should be played by OH professionals. Suggestions for overcoming these barriers and improving the rehabilitation process were also considerably developed at each stage. More emphasis was also added regarding the on-going initiatives in rehabilitation practice and the roles of other health professionals. The final outcome was agreement that consensus had indeed been reached and agreement that it should be published with its accompanying participant list. The consensus statement is published in this issue of *Occupational Medicine* (pp. 253–254).

Discussion

The consensus statement makes a number of clear observations about the importance of rehabilitation for work, the respective roles of GPs and OH professionals, and the barriers created by the current situation of poor communication. Importantly, it also makes recommendations about how to overcome the barriers and some novel suggestions to take the agenda forward to the advantage of all stakeholders. Although there is a lack of literature on this topic, there is sufficient to give credence to the statement, including the beginning of an evidence base [14].

The observation that rehabilitation for work is high on the national agenda [2] has been borne out by the publication in the UK of a Green Paper [15], a governmental discussion paper. The focus of the document is assisting those on incapacity benefit back to work, but a significant section addresses the need for employers actively to manage return to work and rehabilitation with the involvement of good quality OH facilities. Also stressed in the document is the vital role played by GPs,

by clinical management and issuing sick notes, but also that they are hindered by a lack of knowledge of OH and fitness for work issues and that the lack of appropriate emphasis on rehabilitation issues can have long-term consequences.

Recent work in The Netherlands looking systematically at barriers to work [14] has for the first time been able to demonstrate that ineffective disability management by treating physicians leads to delays in return to work. It was also demonstrated that this was associated with limited levels of communication between treating physicians and OH professionals. Against a background of a long, intractable record of poor communication and co-operation between GPs and OH professionals in The Netherlands [16], it is encouraging that 80% of both groups want to improve co-operation [16].

In the UK, where GPs think that OH professionals sometimes meddle in primary care [17], 73% desire greater links with OH professionals [17]. One OH professional has put a great deal of effort into building lines of communication with GPs, with considerable success [18]. One marker of her success must be that in only 8 of 91 requests for reports was a fee requested. One GP has a very clear view that the relationship between GPs and OH professionals is not as good as it ought to be and that the misunderstanding by GPs of the role of OH professionals is to the detriment of our mutual patients [19]. He suggests better training in OH issues at undergraduate and GP training levels. This proposal is also contained within the Green Paper [15] and in discussion about assisting GPs in the process of sickness certification [20]. It has, however, been suggested that increased training alone is insufficient and that what is required in addition is collaborative working, with OH leading active rehabilitation in liaison with primary care, with consequent reduction in workload for GPs [21].

The role of GPs with an occupational medicine qualification has been acknowledged [19], but an increased role in rehabilitation for Disability Assessment doctors (including GPs) is a novel suggestion, although it is touched upon in the Green Paper, as is greater involvement of other health care professionals. For these last, this includes pilots looking at extension of sickness certification to community psychiatric nurses, occupational therapists and physiotherapists [15].

The statement gives examples of the initiatives under way which will continue to shape the development of rehabilitation for work over the next few years. It is important that OH professionals participate in these and incorporate their findings into practice [2].

It would thus seem that review of the literature would support the views expressed in the consensus statement and that the Delphi technique has been a valid tool to investigate this subject. This is the first study involving a group of stakeholders for whom rehabilitation for work

is an issue of extreme importance and exploring the complex interactions involved. The named individuals who have participated in the study are important because they were identified from within the study process, they are in positions where their opinions are likely to be valid and have influence and, in some cases, are policy-makers for their organizations. It is hoped that their involvement will achieve one of the other outcomes known to be associated with consensus statements from Delphi studies—that of the potential to promote change [3]. It is important not to see the highlighting of deficiencies as a negative outcome, when the potential benefits of addressing them are so great.

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