Do GPs record the occupation of their patients?

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Background
General practitioners (GPs) have a central role in providing advice about fitness for work, yet there are concerns about their understanding of the relationship between work and health.

Aims
To assess whether GPs in one Cornish practice record the occupation of patients of working age and to quantify how important GPs in Cornwall consider recording of occupation in working-age patients.

Methods
An audit of the notes of 300 working-age patients in one practice, a search of the computer records at a different practice and a questionnaire survey of 202 GPs in practices in Cornwall.

Results
Occupation was recorded in 50 (17%) of the 300 patient notes audited. The questionnaire response rate was 31%. Few (8%) respondents reported training in occupational medicine. Most (65%) of GPs recorded their patients’ occupation some of the time. A third (32%) of GPs did not consider it important to record patients’ occupations.

Conclusions
GPs in two Cornish practices recorded the occupation of working-age patients infrequently, but over two-thirds of GPs in Cornwall believe it is important to do so. If these results reflect the practice of UK GPs, the new ‘e-fit note’ may be of limited value in monitoring and analysing sickness absence.

Key words
Fitness for work; fit note; incapacity; occupational medicine education; primary health care; sickness absence; sickness certification.

Introduction
In 2009/2010, 1.3 million working-age adults in the UK reported illness that they believed to be caused or exacerbated by their work, resulting in 23.4 million working days lost and a major impact on the UK economy. The most common work-related health problems reported were musculoskeletal problems and mental ill-health [1].

General practitioners (GPs) have a central role in providing advice about fitness for work to patients who request, or who they consider should be provided with, sickness certification. GPs should be able to offer simple fitness for work advice and support to aid their patients’ recovery and to help them stay in or return to work [2]. However, the Black report raised concerns about the lack of understanding of the relationship between work and patients’ health and the omission of this issue from professional training [3].

The only national database of work-related ill-health seen in UK general practice is THOR-GP, run by the University of Manchester. GPs reporting to THOR-GP all have training in occupational medicine (OM) at least to diploma level [4].

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five full-time equivalent principles (three male, two female) in a nearby larger town. In this practice the whole working age population was searched, and we were only able to identify records in which occupation had been coded.

Additionally we sent a questionnaire to 202 GPs in practices in Cornwall on the GP database of the Peninsula Medical School, Truro faculty. We asked about GPs’ age, gender and interval since qualification, whether they had training in OM, how often they recorded patients’ occupations in consultations, why they did not record it and whether they considered it important to record patients’ occupations.

Results

The manual search of records in the first practice revealed that the patient’s occupation was recorded in 50 of the 300 patient notes audited (17%). The GP recorded that the patient had a work-related illness in 50 of the 300 records reviewed, but the patient’s occupation was not recorded in 15 of these 50 records.

Musculoskeletal problems (17/50) and mental ill-health (18/50) accounted for 70% of the cases of recorded work-related illness. The search of computerized records at the second practice found that of 5568 working-age patients registered, only 630 patients (11%) had their occupation recorded and coded. None of the GPs in either practice had received training in OM.

We received 63 survey questionnaires from 202 GPs (31%). The mean age of responders was 45 (SD = 8 years). There were 41 male and 22 female GPs and the mean time since qualification was 21 years (SD = 8 years).

Questionnaire responses on the frequency of recording of occupation and the importance of doing so are summarized in Table 1. Time limitations and lack of relevance were the most common reasons given for non-recording.

Discussion

We found low levels of recording occupation by GPs in Cornwall, although over two-thirds who responded to a questionnaire believed it is important to do so. Responses were similar for GPs with and without training in OM, but only five (8%) had training in OM.

The findings from our manual audit of data from one practice and electronic search of a larger dataset at another are supported by the responses to our questionnaire sent to GPs in the same county. The small sample and the low response rate in the questionnaire survey are weaknesses.

It is possible that a small number of cases were missed in the electronic search, because occupation may have been recorded without being coded. However, the computer system used throughout Cornwall prompts coding. Respondents to questionnaires are more likely to be interested in the subject, so the reported frequency and importance of occupation recording may be overestimated by the survey responses.

Although work-related illness is common, GPs only sometimes record their patients’ occupation. The absence of training in OM among most of the GPs responding to our questionnaire may partly explain this. The Society of Occupational Medicine reports that 30% of their GP members have no training in OM and only 46% of GPs providing occupational health services to the British army have any occupational health training [5,6].

The only available formal training in OM below diploma level is the ‘health and work in general practice’ programme run jointly by the Royal College of General Practitioners and the Faculty of Occupational Medicine [7]. A recent review of systems for recording sickness absence from musculoskeletal causes in Great Britain concluded that these systems were fragmentary and incomplete and that sickness absence is rarely recorded accurately [6].

The Department for Work and Pensions (DWP) plans the introduction of an electronic fit-note (e-fit note) in 2012. It is claimed that the e-fit note will facilitate monitoring and analysis of the use of fit notes by GPs and inevitably lead to changes in practice [8]. The value of the e-fit note will however depend on the accuracy and completeness of data entry. Our findings suggest that there is much work to be done in training GPs before the e-fit note may become a useful tool in epidemiology or in the management of sickness absence.

Table 1. Responses to questionnaire by training in OM

<table>
<thead>
<tr>
<th>Responses to questionnaire: recording of occupation</th>
<th>Respondents with training in OM n (%)</th>
<th>Respondents with no training in OM n (%)</th>
<th>Total n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only when relevant</td>
<td>1 (25)</td>
<td>13 (22)</td>
<td>14 (22)</td>
</tr>
<tr>
<td>Some of the time</td>
<td>3 (60)</td>
<td>38 (66)</td>
<td>41 (65)</td>
</tr>
<tr>
<td>Majority of the time</td>
<td>1 (25)</td>
<td>6 (10)</td>
<td>7 (11)</td>
</tr>
<tr>
<td>All the time</td>
<td>0 (0)</td>
<td>1 (2)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Consider it important to record occupation</td>
<td>4 (80)</td>
<td>40 (69)</td>
<td>44 (70)</td>
</tr>
<tr>
<td>Total</td>
<td>5 (8)</td>
<td>58 (92)</td>
<td>63 (100)</td>
</tr>
</tbody>
</table>

Key points

- General practitioners in Cornwall record their patients’ occupation infrequently and inconsistently despite a majority of them believing that it is important to do so.
- If these findings reflect UK practice in primary care, the value of the e-fit note for monitoring and analysis of sickness absence is likely to be limited.
- There is much to be done in training GPs if the e-fit note is to become a useful tool in epidemiology or in the management of sickness absence.
Conflicts of interest

None declared.

References


The ex-service men’s maternity ward

This picture was taken in about 1969 whilst cycling through the Sangli District in southern Maharashtra state, India. I am unsure if the building stands any longer. The maternity ward was evidently built as an adjunct to the Sangli Civil Hospital for the benefit of veterans’ families, and accompanied a rest-home and hostel serving the same group [1]. Though clearly, and unironically, constructed ‘to care for him who shall have borne the battle and for his widow and his orphan’, in the words of Lincoln’s Second Inaugural Address [2], 40 years on we may see its purpose very differently. Women soldiers serve in India in similar positions as in the USA, UK and most other countries, though not without familiar debate as to their role in combat. Women’s health and maternity care therefore becomes a benefit of their own service, rather than a family perquisite of the male soldier’s commission.

My own odd-ball thoughts on the picture, though, stem from my work in the epidemiology of occupational hazards in pregnancy. Evidence has slowly built that work tasks and exposures vary by gender, even within the ostensibly same job title [3]. Here is the golden opportunity to have a counterfactual population to study and contrast with my own subjects, namely men who have become pregnant. Just imagine the research questions that might be answered therein.

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References