RESEARCH

Occupational stress: a survey of management in general practice

Grant M Russell and Sally M Roach

ABSTRACT

Objectives: To identify approaches to and barriers associated with the management of patients with work-related stress by general practitioners (GPs).

Design: Cross-sectional postal survey using a self-administered questionnaire which included a case vignette of a patient with work-related stress and questions ascertaining perceived barriers to the effective general practice management of work-related stress.

Participants and setting: 450 Western Australian GPs on the mailing list of a GP journal. The survey was conducted between 22 March and 28 April 2000.

Main outcome measures: Likelihood that GPs would (i) choose to open a workers compensation claim and (ii) provide time off work for the patient described in the vignette.

Results: Response rate was 50.1%. Eighty-five per cent (95% CI, 79.6%–89.7%) of respondents advised the hypothetical patient to take time away from work; however, only 44.0% (95% CI, 37.2%–50.7%) chose to initiate a workers compensation claim. GPs with training or experience in occupational health were less likely to advise the patient to stay away from work (odds ratio [OR], 0.30; 95% CI, 0.12–0.73), but were just as likely to initiate a claim. GPs were reluctant to involve the employer in management decisions, because of concern about patient confidentiality and the potential to make matters worse for the patient. These, and the adversarial nature of the workers compensation system, were the strongest perceived barriers to effective management of the condition.

Conclusions: Our findings indicate that general practitioners take a pragmatic and varied approach to the management of work-related stress. The perceived difficulties with contacting employers challenges the principles of injury management within a workers compensation system which is dependent on liaison between system stakeholders.

MJA 2002; 176: 367–370

EVIDENCE IS ACCUMULATING on the adverse effects of psychological stress in the workplace. While linked with coronary heart disease, hypertension, peptic ulcers and type 2 diabetes,[1,2] the most direct indicator of its effect has been the dramatic increase in the number and cost of associated workers compensation claims for work-related (occupational) stress.

Most Australian States have had similar experiences to those of Western Australia (WA), where the incidence of work-related stress claims doubled between 1994 and 1997, accounting for 2.2% of all workers compensation costs by 1998. In WA, stress claims take twice as long to settle, and cost the workers compensation system twice as much as non-stress claims.[3]

Published Australian guidelines for the medical management of occupational stress advocate early intervention; durable, monitored return to work; and effective communication between all parties in the system.[4] The principle of effective communication underpins the recent implementation of the principles of "injury management" to Australian workers compensation systems. Injury management in WA (Box 1[5]) aims to facilitate communication and decision making between workers, employers and medical practitioners.[5]

Although Australian general practitioners are generally the first point of contact for entry into the workers compensation system, surprisingly few studies have investigated the role of GPs in managing workplace injuries. None have explored the role of GPs in managing work-related stress, and this study formed part of a larger investigation into the role of GPs in managing this condition.[4] The published study, funded by WorkCover WA, involved literature review and qualitative data collection by focus groups and key informant interviews with significant participants in the workers compensation system in WA. Its findings informed the design of this study, which aimed to identify approaches to and barriers associated with the management of work-related stress by Western Australian GPs.

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C/- Centre for Studies in Family Medicine, London, Ontario, Canada.
Grant M Russell, FRACGP MFM (Monash), Saw Research Fellow and PhD Scholar, University of Western Australia. University of Western Ontario Department of Family Medicine.
Western Australian Research Unit of the Royal Australian College of General Practitioners, Perth, WA.
Sally M Roach, PhD, PostGradDip, BAppSc, Assistant Director.
Reprints: Dr Grant M Russell, C/- WA Research Unit, The Royal Australian College of General Practitioners, 17 Lemnos St, Shenton Park, WA 6008.
grussell@uwo.ca

METHODS

Study population

An anonymous postal survey was conducted between 22 March and 28 April 2000. Questionnaires were mailed to 450 Western Australian GPs randomly selected from the mailing list of *Australian Family Physician*. Non-respondents at three weeks were mailed a copy of the questionnaire with a modified letter of introduction.

The questionnaire

The 30-item, self-completion questionnaire was based on themes elicited from the qualitative data of the parent study.

1: Injury management criteria in the Western Australian workers compensation system[5]

- The general practitioner (GP) is the gatekeeper to the system
- The GP decides on management and communicates with the employer (by telephone and/or facsimile) and the insurer (by the first medical certificate)
- The worker is given standard information on injury management by the GP
- Subsequent management is undertaken in consultation with the employer
- A second medical review should take place within 14 days
- The employer, insurer and medical practitioner may jointly decide on the need for vocational rehabilitation

Piloted with a convenience sample of five GPs, it comprised three sections, described below.

- A case vignette of a hypothetical patient with work-related stress (Box 2[6]). Respondents were asked to indicate management decisions regarding time off work, advice concerning lodgment of a workers compensation claim, involvement of other professionals in patient care, and plans for employer contact.
- Likert-style questions giving five options across a range, ascertaining potential barriers to the effective management of work-related stress: (i) confidence in management skills, knowledge of claim requirements, and perceptions of financial and organisational barriers to management; (ii) experiences with contacting employers; and (iii) attitudes to accreditation of GPs to work within the workers compensation system.
- Demographic data (sex, age, practice location, years in general practice, number of sessions worked per week and past involvement in occupational medicine). Respondents who had worked as a company doctor or who had had special training or qualifications in occupational medicine were categorised as having "experience in occupational medicine". Rural practice location was assessed by linking postcode with the Rural and Remote Metropolitan Areas classification,[7] while "urban" represented practitioners working in Perth and centres with populations over 75 000. Other locations were categorised as "rural".

2: Case vignette[6] and respondents' management decisions

Peter, 32, is an office manager who presents with symptoms typical of an anxiety state — intermittent diarrhoea, insomnia, palpitations and, at times, reactions bordering on panic attacks. You have treated Peter and his family for many years and have not previously known of any substantial psychological problem. Indeed, he has always struck you as a reasonably easygoing type. He says now that his anxiety is due to difficulties he is having at his workplace. His company went through a merger six months ago and he found himself with a new boss, with whom he does not get along. His work environment has been restructured. Peter believes his symptoms are mainly the result of this work stress and that he will need a minimum of a few days off work.

Management decision	Number	Proportion (%)	95% Confidence Interval
Workers compensation claim (n =207)			
Would initiate	91	44.0	37.5%–50.7%
Would not initiate	116	56.0	49.3%–62.8%
Fitness for work (n =195)			
Fully fit	10	5.1	2.0%–8.2%
Partially fit	20	10.3	6.0%–14.5%
Totally unfit	165	84.6	79.6%–89.7%
Suggested time away from work if certified fully unfit (n =163)			
1-7 days	144	88.3	83.4%–93.3%
8-14 days	16	9.8	5.2%–14.4%
> 14 days	3	1.8	0–3.9%
Timing of employer contact (n=91)			
During the consultation	7	7.7	2.2%–13.2%
That day	14	15.4	8.0%–22.8%
Within one week	14	15.4	8.0%–22.8%
Wait for employer to contact	44	48.3	38.1%–58.6%
Other	12	13.2	6.2%–20.1%
First referral choice (n=176)			
Psychologist	123	69.9	63.1%–76.7%
Psychiatrist	22	12.5	7.6%–17.4%
Employer-related service	12	6.8	3.1%–10.5%
Miscellaneous*	19	10.8	6.2%–15.4%

*Included 10 counsellors, 5 rehabilitation providers, 2 GPs with special interests, 1 occupational therapist and 1 occupational health physician

Ethics approval

Ethical approval was provided by the Royal Australian College of General Practitioners' Research and Evaluation Ethics Committee.

Data analysis

Data were analysed with SPSS-PC version 9.0.[8] Analysis used descriptive statistics, frequencies, cross-tabulations and Pearson χ^2 tests. Ten logistic regressions were performed as follows:

- Two for the *dependent variables* regarding initial management of the case vignette (proportion of GPs opening a workers compensation claim, and proportion of GPs advising time off work).
- Eight for *dependent variables* of perceived barriers to effective management of work-related stress (appropriateness of reimbursement; the adversarial system; lack of confidence in specific requirements to lodge a stress claim; time available to manage the case; accreditation of general practitioners within the workers compensation system; and whether respondents perceived employer contact as (i) compromising confidentiality, (ii) making things worse for the worker, and (iii) difficult to achieve).

Independent variables were sex, sessions worked per week (less than six or six or more), years in general practice (less than six or six or more), practice location (urban or rural), and

experience in occupational medicine (no experience or experience). The respondent's confidence in knowledge of the specific requirements for lodging a stress claim was added to the vignette regressions.

RESULTS

Thirty-five of the original 450 GPs (7.7%) were ineligible to participate as they were no longer in general practice, on leave, or unable to be contacted. Of the remaining 415, 208 returned questionnaires (response rate, 50.1%). The sample was demographically similar to the WA GP workforce.[9] The respondents consulted for an average of 7.6 sessions per week (95% CI, 7.2–8.0 sessions) and had worked in general practice for an average of 16.8 years (95% CI, 15.4–18.3 years). A fifth (19.7%; 95% CI, 14.3%–25.1%) had had some experience in occupational medicine.

Management of the patient described in the case vignette

Less than half (44.0%; 95% CI, 37.2%–50.7%) of the respondents would have advised the patient to lodge a workers compensation claim at the first visit (Box 2). Box 2 also shows that the vast majority (84.6%) would have considered the patient totally unfit for work, with 88.3% of these suggesting the patient take no more than one week off. Respondents who would have initiated a workers compensation claim were no more likely than those who would not have initiated a claim to certify the worker as unfit (data not shown).

Box 3 shows results of the multiple logistic regressions. Practitioners more likely to open a workers compensation claim were female and those confident in their knowledge of the legislative requirements for opening a work-related stress claim. Those with experience in occupational medicine were significantly less likely to certify the worker as being totally unfit for work.

GPs who would not have opened claims outlined alternative management strategies in open responses. These included the use of a cooling-off period before early review; exclusion of organic disease; and brief, non-compensated sick leave. Many suggested that a claim could be opened subsequently given informed consent. One GPs response was typical: *"I would advise him to consider his options, take a few days' regular sick leave as a circuit breaker and then see how he feels. I would ask him to consider his longer term goals."*

3: Multivariate logistic regression analysis of variables associated with decisions on claim lodgement and fitness for work.

Independent variable	Odds ratio	95% CI	*P*
Likelihood that respondent would open workers compensation claim at first visit			
Female sex	2.22	1.10–4.35	0.027
Confidence in knowledge of specific requirements	2.48	1.27–4.84	0.008
Likelihood that respondent would certify patient as totally unfit for work			
Experience in occupational health	0.30	0.12–0.73	0.008

Represents logistic regression with dependent variable of proportion of GPs opening a workers compensation claim and proportion of GPs certifying patient completely unfit for work. Independent variables: sex, sessions worked per week (<6 or ⩾6), years in general practice (<6 or ⩾6), practice location (urban or rural), experience or no experience in occupational health, response to statement "I am confident that I know the specific requirements to lodge a work-related stress claim" (agree or strongly agree v other responses).

Barriers to effective management

Sixty-four per cent of GPs indicated confidence in their ability to manage patients suffering from work-related stress (data not shown). By contrast, only a third agreed with the statement that they felt confident in their knowledge of the specific legislative requirements involved in lodging a work-related stress claim. Box 4 summarises responses to this and other questions ascertaining GPs' perceptions of barriers to effective management. A third (31.3%) agreed with the statement that "Accreditation of GPs to be able to work in the area of workers' compensation will result in optimal management of work-related stress". Many of those opposed to this view provided open responses about the importance of GPs in workers compensation, the value of continuity and the potential problems posed by restrictive accreditation in rural areas: One rural GP wrote: *"I work in an area where GPs are very scarce. If some fail to be accredited or don't apply then where will our patients go?"*.

DISCUSSION

Australian guidelines for the medical management of work-related stress suggest that cases be evaluated in the light of legislative criteria. The guidelines discourage time off work and favour early referral to mental health specialists.[10] The study findings suggest that Western Australian GPs have a pragmatic and reasonably cautious approach to early management. Most chose not to initiate a workers compensation claim in response to the case vignette describing a patient with work-related stress. Most would have advised this patient to take up to a week off work whether or not a claim was lodged, would have involved a psychologist in further management, and would have waited for the employer to initiate communication.

Our study had several limitations. The response rate of 50.1%, while consistent with contemporary GP questionnaire studies,[11] potentially limits generalisability. Also, while case vignettes can be used as proxies for actual management decisions within general practice research, they tend to overestimate real performance.[12] While a larger sample size might have clarified associations between variables, the study was primarily designed to explore management decisions and ascertain important barriers to effective care.

Our findings are consistent with those of other studies which have found that GPs formally report only a third to a half of compensable workplace conditions,[10,13] and contrast with employer and insurer perceptions of doctors being too willing to initiate claims.[14] We are not aware of any other studies which have found different claim rates between female and male GPs, and believe that this warrants further investigation.

At the time we conducted the survey, Western Australian GPs seeking to open

4: Multivariate logistic regression analysis of variables associated with GPs' perceptions of barriers to effective management of patients with work-related stress

Perceived barrier	Proportion agreeing or strongly agreeing (95% CI)	Independent variables increasing agreement*	OR (95%CI)
The adversarial system	78.8% (75.8%–81.8%)	NS	
Lack of confidence in knowledge of specific requirements to lodge a work-related stress claim†	66.3% (62.6%–70.8%)	Part-time Rural practice location	2.63 (1.06–6.67) 3.86 (1.32–11.22)
Contacting the employer compromises patient confidentiality	55.3% (51.5%–59.1%)	NS	
Contacting the employer may make things worse for the patient	53.4% (49.4%–57.4%)	NS	
Inappropriate payment†	49.5% (45.3%–53.7%)	NS	
Insufficient time†	44.7% (40.9%–48.5%)	Rural practice location	2.96 (1.22–7.17)
Difficult to contact employers	35.6% (31.3%–39.9%)	Full-time	4.08 (1.62–10.25)
Accreditation should optimise management	31.3% (27.5%–35.1%)	NS	

* Based on eight separate logistic regressions with dependent variables of respondents agreeing or strongly agreeing with each barrier and independent variables of sex, sessions worked per week (part-time GPs were those working 5 or fewer sessions per week; full-time GPs were those working 6 or more sessions per week), years in general practice (< 6 or ⩾ 6 years), practice location (urban or rural), and experience in occupational health.
† Categories have been reversed from questionnaire. NS = not significant

a stress claim had no easily accessible information on the necessary criteria for a claim to be accepted. Given this, it was not surprising that two-thirds of the respondents (especially part-time GPs and those from rural areas) were uncertain about the legislative requirements for work-related stress claims. However, the finding that perceived knowledge of legislative requirements increased the likelihood that the respondent would initiate a claim is intriguing.

Occupationally experienced GPs were less likely to certify the hypothetical patient as totally unfit for work, a finding possibly explained by their increased familiarity with the options for flexible work arrangements for impaired workers. In isolation, this would support the recommendations of a recent review which advocated mandatory training for GPs if they were to register to practise within the Western Australian workers compensation system.[4] However, these GPs were just as likely to initiate a claim, defer employer contact or be confident of legislative requirements as their peers.

Injury management

Three in four respondents thought injury management in work-related stress was compromised by the adversarial nature of the workers compensation system. GPs viewed communication as being made more difficult by concerns about patient confidentiality, uncertainty about effective methods of negotiation, and awareness of the potential for making things worse for the patient. Employer liaison seemed particularly challenging for full-time practitioners, who may find it difficult to schedule what may be a challenging telephone call into a day filled with other clinical responsibilities.

Our results suggest that, at least in cases of work-related stress, it would be premature for workers compensation providers to assume that smooth injury management will result from a strategy based on increasing provider knowledge. From the perspective of the insurer, increasing GPs' knowledge about work-related stress could reduce the number of patients offered time away from work, but increase the number of claims initiated. Philosophically, a limited provider system would seem to challenge the ideals behind injury management and have major ramifications for distressed workers, especially those from remote areas.

Our study suggests that interventions to improve the management of work-related stress by GPs would be best directed at addressing the challenges of implementing injury management. Our findings suggest that further exploration should be made of the impact of injury management on clinicians, employers and employees. It seems unlikely that the systemic barriers identified in this study would be confined to issues relating to work-related stress.

ACKNOWLEDGEMENTS

We thank Professor Moira Stewart and Ms Anne Grindrod (both of the Centre for Studies in Family Medicine at the University of Western Ontario, Canada) for their assistance in the analysis of the study results.The study was funded by a research grant from WorkCover WA

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(Received 4 Jun, accepted 10 Dec 2001) ❑