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5.3 Cooperation of General Practitioners and Occupational Physicians: Identity, Trust and Responsibility

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INTRODUCTION

In the Netherlands general practitioners (GPs) and occupational physicians (OPs) do not cooperate very well. To improve this cooperation several projects have been developed. Better cooperation should lead to: less contrasting advice from different doctors; quicker rehabilitation and less days of sick leave; quicker diagnosis of occupational diseases by GPs. Another study about the cooperation of GPs and OPs dealt with problems like time, practical and financial aspects (Buijs, Van Amstel & Van Dijk, 1999). In our study we take a social psychological point of view looking at the GPs and OPs as members of different professional groups (Brown, 1996). We were interested in the effects of group membership on cooperation. Firstly, we studied the effect of perceived identity and relative position on their cooperation. Secondly, we studied the effects of dependency and trust, thirdly the effects of the perceived responsibility.

Identity and relative position

People find it important to participate in a group, it gives them a part of their identity, in this case *occupational identity*. Being a member of a group enhances comparison processes with comparable groups. The position in respect to the position of the other group is calculated. Members of the one group compare themselves with members of the other group with respect to dimensions such as professional knowledge, professional experience and power. A perceived higher or lower position on one of these dimensions can have negative effects on the cooperation. The more these positions are apart from each other, the more the cooperation can be hindered.

Dependency and trust

Cooperation supposes interdependency. To reach a high standard of work GPs and OPs are dependent on each other. The degree of interdependency can be felt differently by each party. Being dependent on someone requires that you have to trust that person. This means that you know that the other will make a correct use of your information. We distinguished two dimensions: trust in the content of the work

and trust in the communication (the process). Trust is usually built in a longer lasting relationship in which the interaction develops positively. But the GP-OP relationship is mostly a contact about one patient and in most cases there is no longer lasting personal tie between the two doctors. This means that the level of trust in the other is connected to the level of trust in the other as a representative of the other profession. We think that quality of cooperation between GPs and OPs is related to dependency and trust.

Responsibility

When the division of responsibilities between the two occupational groups is not clear, the members of these groups can get irritated and feel threatened when they have to cooperate with the other. Boundaries of the territories must be defined. Which tasks are important for whom (see relative position)? Is the division of responsibilities fair and efficient?

The cooperation of GPs and consultants in hospitals has been studied by De Greve (1983), who pointed out that they need each other mutually and cooperate well when the division of responsibilities is clear. Otherwise irritations occur. Especially when the boundaries between the groups are not obvious, when there is less mutual trust and there is strong dependency. Our hypothesis is that this phenomenon also exists in the relation of GPs and OPs.

METHOD

We developed a questionnaire with items about identity, relative position, dependency, trust and responsibility. The questions about dependency and responsibility were related to daily tasks in practice. For trust, identity and relative position we presented statements. The identity scale consisted of 5 items (e.g. I never think about giving up my job as a GP/OP). The relative position scale consisted of 2 items (e.g. "To function adequately as a GP/OP you need compared to the OP/GP knowledge in more areas"). The trust scale consists of six items (e.g. "I trust the way OPs/GPs make somatic diagnoses"). Three items were on work related trust, three on process related trust.

The questionnaire was sent to more than 2000 GPs and OPs in the South West of the Netherlands. We invited them in the same letter for two meetings in Rotterdam. The questionnaire could be returned separately and anonymous. We could use the data of 338 GPs and 209 OPs. 19,6 % of the GPs and 36,7 % of the OPs responded, which is rather satisfactory for this type of mail survey study.

RESULTS

Characteristics of the respondents

The characteristics of the respondents strongly resemble the respondents of Buijs et al (1999) in respect of age, sex and type of employment. We do not know if our sample is representative in respect of opinions.

Professional identity and relative position

In all comparisons between GPs and OPs we took age, sex, working hours per week and number of contacts as covariates.

The scores of the GPs are significantly higher than of the OPs on both mechanisms. The results are as we expected. OPs live in a difficult time since there have been many changes in social laws. There have been other results which stated that many OPs appeared to be unhappy with their job.

GPs find that they need more knowledge and skills than OPs. On the other hand the OPs do find this to a lesser degree. We know informally there is a pecking order among doctors (Meulenberg, 1998), recently we found a study confirming this (Medische Profielenboek).

Trust in work and communication

OPs have more trust in the work of GPs than the other way round. This is as expected. But the trust that GPs have in OPs is not low: mean score 10.42 (score 9 would be 'neutral').

GPs have significantly more trust in the process of communication with the OPs than the other way round. We had not expected that. A possible reason is that our questions were about work related disorders. It is also possible that the distrust of GPs about OPs (which we hear about) concerns specific parts of the work that were not in our questionnaire.

Dependency and responsibility

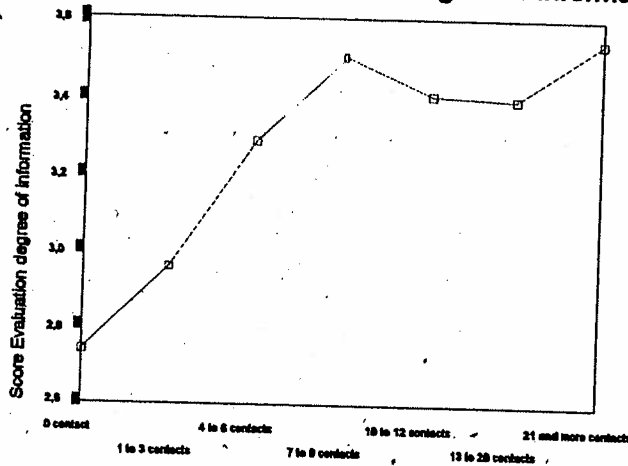
OPs feel significantly more dependent on GPs than GPs on OPs. This is as we expected. GPs often have more details about the patient's illness like letters from consultants, they know the family and the personal history. In fact, GPs are as dependent because the OP has information about the workplace and the harmful circumstances in the workplace. But they do not perceive this dependency.

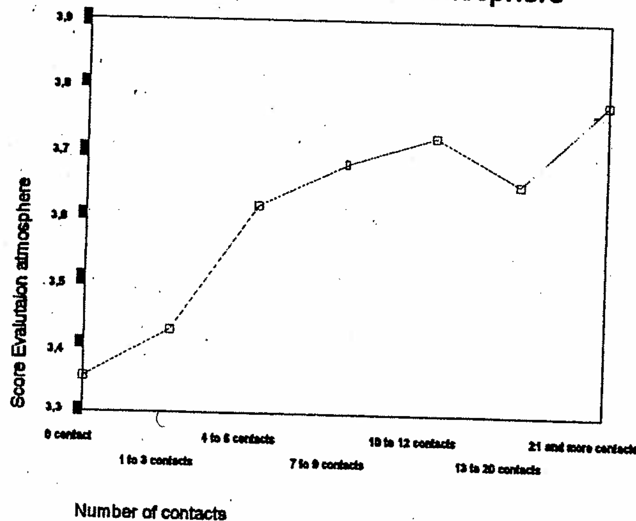
GPs find themselves more responsible for the activities in the list. They are the 'gatekeepers' of the health care system. We know that GPs do not want OPs to do curative tasks. Is this a territorial fight? The professional association of OPs (NVAB) states that a limited number of curative acts are the OP's task. These

include referral to paramedics and to consultants for diagnostics (Domus Commissie, 1997).

Number of contacts

Firstly, in the total group there is a significant positive relation between the number of contacts and the evaluation of the interaction (atmosphere and degree of information ($p < 0.05$) (figures 1 and 2).





Figures 1 and 2: Means of number of contacts in relation to the evaluation of the contact (covariates: age, sex, number of working hours per week) GPs and OPs together

Secondly, we find in the total group a positive relation between the number of contacts and trust in the communication with the other ($p < 0.02$) (figure 3).

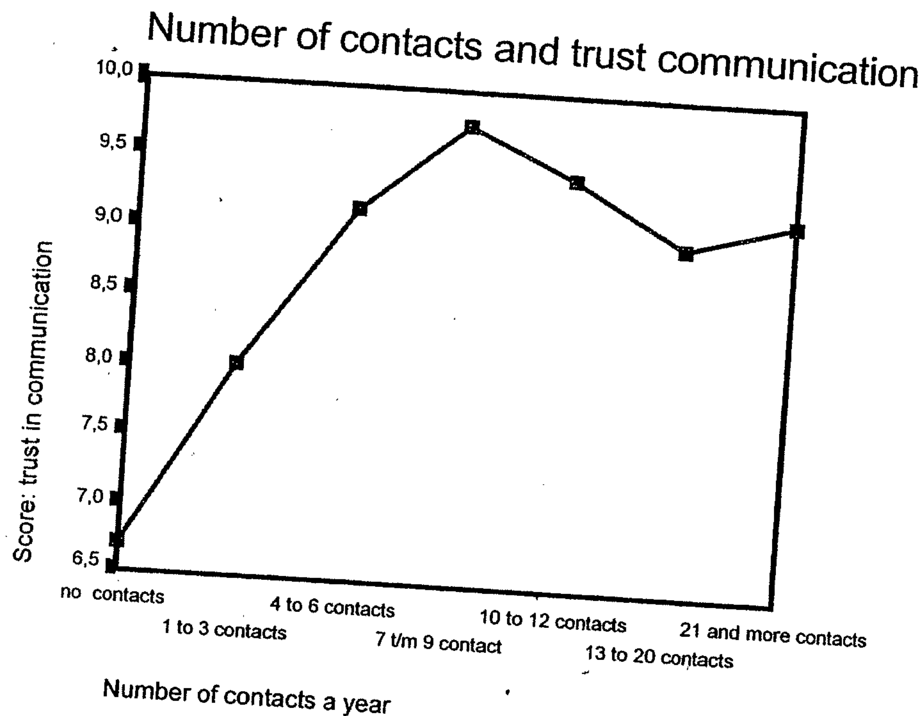


Figure 3: Means of number of contacts in relation to trust in the communication (GPs and OPs together) (covariates: age, sex, number of working hours per week, profession)

This result is related to the first point above. We think there is mutual beneficial influence: by speaking and interacting more trust is built. Having more trust leads to a stronger intention to interact. This process reinforces itself.

Thirdly, the number of contacts had no influence on trust *in the work* of the other, ($p < 0.15$), the dependency ($p < 0.46$), the professional identity ($p < 0.09$) or the relative position ($p < 0.66$). (No figures.)

Correlation of social psychological mechanisms

The social psychological mechanisms dependency, trust and responsibility correlate (see table 1).

Table 1: Correlations between dependency, trust and responsibility, GPs and OPs together (Pearson correlation coefficients, two sided)

	Dependency	*Trust in work*	*Trust in communication*
Trust in work	.26 N=533 p < 0,000		
Trust in communication	.03 N=533 p < 0,468	.43 N=536 p < 0,000	
Responsibility	-.45 N=489 p < 0,000	-.21 N=488 p < 0,000	.03 N=489 p < 0,469

This tends to confirm our hypotheses about the cooperation of the professions. We want to explore this correlation in a future study.

CONCLUSIONS

Our study shows that different social psychological mechanisms have a profound effect on the quality of the cooperation of GPs and OPs. Especially we found significant differences between the two professions in professional identity, relative position, dependency, trust and responsibility.

There is a significant relation between the number of contacts and the evaluation of the contacts and between the number of contacts and trust in the communication. Apparently trust in the quality of the work is not the problem.

Our results suggest ways of improving education and training.

On base of our findings we suggest the following interventions:

1. OPs should improve their own professional identity. They should work on internal contacts and create a more cohesive group. The professional group should present itself more clearly. The professional association of OPs could play a prominent role in this. This association is already active in producing standards and composing a declaration of intent. These are useful steps in this view.
2. GPs need to be better informed about what an OP does. It will then be clearer in which respects the well-being of the patient will gain quality when they use the expertise of OPs. Accepting and using the mutual dependency of GP and OP is beneficial for the patient.
3. More possibilities for contacts between GPs and OPs. They could for instance talk about the division of tasks and responsibilities; also about communication.

Talking as equal colleagues is the most important factor, having a communal problem: the patient.

So: better known makes better loved!

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