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# General practitioners' management of patients consulting for "mental distress at work"

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## Abstract.

**BACKGROUND:** Mental distress at work is a complex multifactorial phenomenon liable to impact health and personal life.

**OBJECTIVE:** To assess the proportion of general practice consultations for mental distress at work and determine how general practitioners (GPs) manage these patients and the factors leading to consultation.

**METHODS:** The frequency of consultations for mental distress at work was assessed on a self-administered questionnaire sent to the general practitioners (GPs) of the Loire administrative Département (France). Information on factors leading to consultation on management was obtained by a self-administered questionnaire in a sample of GPs and patients.

**RESULTS:** Twenty-two patients were included by 16 GPs. 27% of patients were referred to an occupational physician. The frequency of consultations for mental distress at work was about 2%. Patients may wait several weeks or months before consulting, although a majority reported an impact on family life and health. A triggering event was often present, but no work accident procedure was undertaken.

**CONCLUSION:** This study highlights the importance of better identifying adverse experience of working conditions and impaired mental health and reporting this to an occupational physician who can undertake preventive measures. Communication between occupational physician, employee and GP needs to be improved.

Keywords: Medical consultations, psychosocial risk factors, work-related common mental disorders

## 1. Introduction

Among work-related diseases, mental health problems are the second most frequent group after musculoskeletal disorders and the first cause of work-related sickness [1, 2]. Previous studies have shown that common mental disorders (CMD) can be related to work characteristics such as: job insecurity, work-

ing hours, work social support, decision latitude, decision authority, effort reward imbalance of job strain [3–6]. In France, data from the national health insurance show that 20% of sickness absences are caused by mental disorders, and this proportion is even higher for long-term sickness absences (on average 111 days) [6]. The social cost of stress, related to healthcare expenditure, absenteeism, early retirement and premature death, amounted to €2-3 bn in 2007 [7]. In 2016, applications for psychological pathology to be recognized as an occupational disorder were accepted in 596 cases, 40% up on 2015. According to

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Rivière et al., in primary care, prevalence estimates of CMD range from 3% to 25% for anxiety disorders and 6% to 25% for depression [6]. General practitioners (GPs) are key players in the management of patients consulting for mental distress at work, setting up individualized medical follow-up with specialist referral if need be. On the frontline for individuals with mental health problems, they often deal with work-related common psychiatric disorders [4]. To our knowledge, a few studies have evaluated the prevalence of work-related mental disorders [4, 8].

The present study assessed the frequency of consultation for mental distress at work, GPs' medical management and the factors underlying consultation.

## 2. Methods

The study was approved by the French data protection commission on November 21, 2016, and by University Hospital ethics committee on January 13, 2017 (IRBN032017/CHUSTE). A self-administered questionnaire was e-mailed to all GPs ( $n=800$ ) in the Loire administrative department of France via the local Order of Medicine (OM), to be filled out on-line using the LimeSurvey application. Data were secured and anonymized. Respondents could make free comments at the end of the questionnaire.

Survey variables comprised sociodemographic data (age, gender) and occupational data (working time per week, number of consultations for mental distress at work, type of medical treatment). The rate of consultations for mental distress at work was determined by dividing the number of patients consulting the GP per week by the number examined for mental distress at work.

A transversal descriptive study was made of patients in the Loire area consulting their GP for mental distress at work from February to end May 2017, using two self-administered paper questionnaires: one survey was completed by the patient and one survey was completed by the GP. Twenty-two GPs were contacted for this study, and were asked to include patients on the following criteria:

- male or female aged > 18 years;
- first consultation for mental distress at work.

Non-working patients and those unable to read French were excluded.

GPs received a document explaining the study procedure, inclusion period and inclusion and exclusion criteria, and were asked to provide patients with

clear, honest and appropriate oral information; eligible patients also received a written information document. Patients were free to decline to take part in the study without impact on treatment.

The patient questionnaire covered:

- socio-occupational and demographic items: age, gender, marital status, socio-occupational category;
- characteristics of the mental distress: symptom onset, trigger factors, impact on personal life and health, level of stress;
- expectations regarding the consultation.

The GP questionnaire covered:

- socio-occupational items: gender, seniority, number of days worked per week; these data were collected using the same questions as in the OM survey of all Loire area GPs, so as to determine the rate of consultation for mental distress at work per GP;
- medical treatment: referral, medical prescription if any, sick-leave if any, diagnosis, etc.

The GP questionnaire was completed at the end of the consultation. The study was approved by the French data protection commission (Commission Nationale de l'Informatique et des Libertés: CNIL) on November 21, 2016, and by University Hospital ethics committee and the regional review board (respectively, January 12, 2017, Ref.: IORG0007394, and June 29, 2017, Ref.: 2017-A01404-49).

Data were rendered anonymous. Descriptive analysis used SAS software, version 9.3 for  $\chi^2$  or Fisher tests to compare frequencies, with the significance threshold set at  $p < 0.05$ .

## 3. Results

Eight hundred GPs were asked by the local Order of Medicine to fill out an on-line questionnaire. 118 (71 female, 47 male) did so: i.e., response rate, 14.7%. Sixteen of the 22 GPs eligible to include patients for the second study did so, and included 22 patients (15 female, 7 male). Socio-occupational characteristics such as gender, seniority and working time did not differ between GPs answering the Order of Medicine survey and those including patients and responding to the study questionnaire (Table 1). The mean rate of consultation for mental distress at work was 2.9% on the OM survey and 2.1% in the study series.

Table 1  
Socio-occupational comparison between General Practitioners (GP) sample and Order of  
Medicine (OM) survey of GPs in the Loire area

Variables		GPs		OM		P-value
		n	%	n	%	
Gender	Male	8	50	47	39.8	0.60
	Female	8	50	71	60.2	
Seniority (years)	<5	2	12.5	30	25.4	0.49
	[5–15]	7	43.7	36	30.5	
	[15–25]	4	25.0	21	17.8	
	≥ 25	3	18.8	31	26.3	
Half-days worked per week	<7	6	37.5	25	21.2	0.16
	[7–8]	2	12.5	16	13.6	
	[8–9]	5	31.3	25	21.2	
	≥9	3	18.7	52	44.0	
Patients per half-day	<10	2	12.5	8	6.8	0.36
	[10–14]	7	43.7	58	49.1	
	[14–15]	2	12.5	6	5.1	
	≥15	5	31.3	46	39.0	
Distress patients per week in last month	0	3	18.7	1	0.8	0.025
	[1–3]	10	62.5	63	53.4	
	[3–4]	2	12.5	17	14.4	
	≥4	1	6.3	37	31.4	

GPs: General Practitioners sample. OM: Loire Order of Medicine survey.

Table 2  
Characteristics of General Practitioners' medical treatment

Variables	n	%	
Longer consultation	No	4	18.2
	Yes	18	81.8
Psychology referral	No	14	63.6
	Yes	8	36.4
Psychiatry referral	No	20	90.9
	Yes	2	9.1
Occupational medicine referral	No	16	72.7
	Yes	6	27.3
Specialist referral	No	22	100
	Yes	0	0
Medical treatment	No	12	54.5
	Yes	10	45.5
Sick-leave certificate	No	0	0
	Yes	22	100
Work accident certificate	No	22	100
	Yes	0	0
Occupational disease certificate	No	22	100
	Yes	0	0
Sick-leave duration	<7 days	1	4.5
	[7–14 days]	11	50.0
	≥ 15 days	10	45.5
Sick-leave reason	Anxiety	5	22.7
	Anxiety-depressive syndrome	8	36.4
	Depression	1	4.5
	Burn-out	5	22.7
	Asthenia	2	9.1
	Bursitis	1	4.5
"Reaction" status declared on medical certificate	No	16	72.7
	Yes	6	27.3

141 Medical management of patients consulting for  
142 the first time for mental distress at work was char-  
143 acterized by longer than usual consultation time,  
144 systematic sick leave (of less than two weeks in half

of the cases), and medical treatment in half of the  
cases. Reasons for sick leave were mental pathology  
(anxiety, depression, anxiety-depressive syndrome)  
in two-thirds of cases and burnout in one-fifth. No

145  
146  
147  
148

Table 3  
Socio-occupational characteristics of patients and GP consultation factors

Variables		n	%	
Demographic data				
Gender	Male	7	31.8	
	Female	15	68.2	
Age (years)	18–25	1	4.6	
	26–35	6	27.3	
	36–45	10	45.5	
	46–55	4	18.2	
	>= 56	1	4.6	
Marital status	Single	5	22.7	
	Partnership	7	31.8	
	Married	9	40.9	
	Divorced	0	0	
	Widowed	1	4.6	
Socio-occupational category	Farmer	0	0	
	Artisan, shop-keeper, CEO	0	0	
	Executive, superior intellectual professional	6	27.3	
	Intermediate professional	2	9.1	
	Office worker	11	50	
	Manual worker	2	9.1	
	Other	1	4.6	
	Duration of distress at work	Days	2	9.1
	Months	14	63.6	
	Years	6	27.3	
Talk before consulting				
No		3	13.6	
Yes	Spouse or partner	13	59.1	
	Friend or relative	9	40.9	
	Hierarchical superior	7	31.8	
	Personnel representative	2	9.1	
	Colleague	10	45.5	
	Psychologist/psychiatrist	1	4.6	
	Occupational medicine staff	3	13.6	
	Labor inspector	0	0	
	Trigger event	Yes	18	81.8
		No	1	4.6
		Don't know	3	13.6
Impact				
Family life	Yes	21	95.5	
	No	1	4.6	
	Don't know	0	0	
Health	Yes	19	86.4	
	No	1	4.6	
	Don't know	2	9.1	
Stress VAS (visual analog scale) 0: no stress; 10: maximum imaginable stress	<7	3	13.6	
	[7–8]	7	31.8	
	[8–9]	5	22.7	
	≥9	7	31.8	
Expectations from consultation				
Listening	No	6	27.3	
	Yes	16	72.7	
Treatment	No	17	77.3	
	Yes	5	22.7	
Sick-leave or work accident	No	8	36.4	
	Yes	14	63.6	
Referral to psychologist/psychiatrist	No	22	100	
	Yes	0	0	
Referral to occupational medicine	No	21	95.4	
	Yes	1	4.6	
Referral to specialist consultation	No	21	95.4	
	Yes	1	4.6	

149 sick leave prescriptions were for work accidents or  
150 occupational disease. One quarter of patients were  
151 referred to an occupational physician (Table 2).

152 More than two-thirds of the patients were under  
153 45 years of age, and one third were single, widowed  
154 or divorced. Mental distress at work showed at least  
155 a few months' progression in most cases. More than  
156 half rated their job stress > 7 on a visual analog scale  
157 (VAS). More than two-thirds identified a trigger fac-  
158 tor. While 86% had already spoken about their mental  
159 distress at work, only 13% had mentioned it to a  
160 member of the occupational medicine team. Most  
161 reported impact on family life and health. Nearly  
162 three-quarters expected the consultation to provide  
163 an opportunity to be listened to, two-thirds expected  
164 a sick-leave prescription, but less than a quarter  
165 expected medical treatment. A minority expected  
166 referral to the occupational physician, a psychologist  
167 or a psychiatrist (Table 3).

#### 168 4. Discussion

169 The frequency of consultations for mental distress  
170 at work was about 2%. Although a majority reported  
171 impact on family life and health, patients may wait  
172 several weeks or months before consulting.

173 The rate of GP consultation for mental distress at  
174 work was about 2%. Héraclès [6], in a series of GPs  
175 in the Nord-Pas-de-Calais Region of France, between  
176 April and August 2014, gave one of the first estimates  
177 of work-related psychological disorder in general  
178 practice: a quarter of working patients presented  
179 work-related psychological suffering. Analysis of  
180 treatment testified to strong GP commitment, with  
181 psychological interviews and medical prescriptions  
182 in most cases and sick-leave in half, but with little  
183 referral to occupational physicians, psychologist or  
184 psychiatrists. The present results likewise found little  
185 communication between GPs/patients and occupa-  
186 tional physicians regarding mental distress at work.

187 A health and job retention policy based on a worker  
188 support approach should include practices targeting  
189 primary and secondary prevention [9]. According to  
190 the French Labor Code (article L. 4622-3), occupa-  
191 tional physicians play a purely preventive role, to  
192 avoid any impairment of workers' health status due  
193 to working conditions, notably by monitoring health  
194 and safety conditions at work, contagion risk and  
195 health status. The occupational physician acts as a  
196 consultant for the management, employees, staff rep-  
197 resentatives and the health and safety and working

198 conditions committee (*Comité d'Hygiène de Sécurité*  
199 *et des Conditions de Travail*), providing advice on  
200 improving living and working conditions in the firm,  
201 adapting work-posts, techniques and work rhythm to  
202 actual human physiology, protecting workers against  
203 nuisances in general and especially work accident  
204 risks or use of dangerous substances.

205 The French health authority (*Haute Autorité de*  
206 *Santé*), in a 2017 report entitled "Clinical identifi-  
207 cation and management of burnout syndrome" [10],  
208 recommends that, with the patient's agreement, the  
209 GP liaise with the occupational physician or an occu-  
210 pational pathology specialist, to raise an alert and  
211 have some information about the workplace. Anal-  
212 ysis of the work-post and working conditions by a  
213 multidisciplinary team coordinated by the occupa-  
214 tional physician is indispensable. Factors hindering  
215 cooperation between GPs and occupational physi-  
216 cians include medical confidentiality and concerns  
217 about the patient's job security [11]. The individ-  
218 ual medical records are not presently available to  
219 the occupational physician, and exchanges with the  
220 GP require the employee's agreement. Few GPs  
221 refer their patients to occupational physicians dur-  
222 ing sick-leave for the purposes of the end-of-leave  
223 consultation [12].

224 To promote return to work after sick-leave  
225 exceeding 3 months, a pre-return consultation with  
226 the occupational physician is set up by the GP,  
227 the national insurance consultant physician or the  
228 patient (Labor Code, Art. R.4624-29), in which  
229 the occupational physician may recommend work-  
230 post adaptation or change or occupational training  
231 to facilitate change of work-post or job. Unless  
232 the employee objects, the occupational physician  
233 informs the employer and the consultant physician  
234 of these recommendations so that all necessary mea-  
235 sures should be taken to ensure return to work (Labor  
236 Code, Art. R. 4624-31).

237 According to the present findings, few patients  
238 spoke about their mental distress at work to any  
239 member of the occupational health department before  
240 consulting their GP. There are numerous factors  
241 hindering communication between employees and  
242 occupational physicians: misapprehension of the role  
243 of the occupational physician and of the possibility of  
244 meeting, difficulty of making contact, lack of a rela-  
245 tion of confidence, and concerns about independence  
246 with respect to the employer [12]. Employees often  
247 mistrust occupational physicians due to the influ-  
248 ence they have over hiring decisions through aptitude  
249 assessment and their role as advisors to the employer

[12]. Occupational physicians, however, actually play a key role in keeping the employee in work.

According to the Labor Code (Art. R. 4624-31 and R. 4624-32), return-to-work consultations with an occupational physician are set up after maternity leave, sick-leave for occupational disease, or more than 30 day's leave for a work accident or non-occupational illness or accident.

The return-to-work examination aims:

- to check that the original or revised work-post is compatible with health status;
- to examine work-post alterations or adaptations or job change proposed by the employer in the light of any occupational medicine recommendations made following the pre-return consultation;
- to recommend work-post alterations or adaptations or job change;
- or, as appropriate, to recommend the employee as inapt to return to work.

The issue of mental distress at work highlights the role of psychosocial risks in the deterioration of employees' mental health [13]. More than three-quarters of GP respondents to a web questionnaire thought GP training on mental distress at work to be inadequate: "Medical school culture does not deal with issues of health at work" [14]. Notably, no work accidents were reported in the present sample, despite patients often reporting trigger factors leading to GP consultation. Certain recent misadventures with the Order of Medicine, which transmitted employers' complaints against practitioners who made the connection between work and ill health, may cause physicians to hesitate to make such work-accident reports. In this context, support from the occupational physician or national health insurance consultant is precious [14]. In work accidents, the relation with working conditions is implicit, and the health insurance authorities do not expect the GP to demonstrate it. The Regional Union of Community Health Professionals (*Union Régionale des Professionnels de Santé Médecins Libéraux*) of the Provence-Alpes-Côte-d'Azur Region of France drew up a guide to distress at work: "*Le médecin libéral face à la souffrance au travail de ses patients*" ("The community physician and patients' distress at work"), listing mistakes to be avoided concerning the terms employed in sick-leave or work-accident certificates: the medical certificate must be strictly descriptive and clinical, dealing with the pathology rather than its cause; thus, the physician should not write anything like

"depressive reaction to working conditions". Equally, "harassment" is a legal term, not a medical diagnosis.

No declarations of occupational disease were made in the present series. In a 2007 study, "*Les médecins face à la santé au travail : une étude qualitative dans le Sud-Est de la France*" ("Physicians and health at work: a qualitative study in South-East France"), under-declaration of occupational disease concerned occupational cancer, asthma and musculoskeletal disorder [15]. Respondent physicians stressed the difficulty of drawing up the initial medical certificate. In regard to mental distress at work, burnout is not a disease recognized in the international classifications (ICD-10 and DSM-5) or in the official French list of occupational diseases. Regional Occupational Disease Recognition Committees (*Comités Régionaux de Reconnaissance des Maladies Professionnelles*: CRRMP) may make decisions on a case-by-case basis, but patients have to show at least 25% permanent incapacity in order to be examined. There are no occupational disease tables in France relating psychosocial risk and mental pathologies; however, a major depressive episode or anxiety disorder may be recognized as an occupational disease by the CRRMP in an "exceptional" procedure provided for in §4, Article L 461-1 of the Health Insurance Code.

Patients' expectations consist above all in wanting their doctor to hear them out. Listening is a fundamental pillar of treatment. According to a 2017 article in the *Revue Médicale de Liège*, "Professional fatigue syndrome (Burnout)", only attentive listening allows the different clinical presentations, somatic and psychological, of distress at work to be interpreted [16]; the authors recommend scheduling a second consultation, to leave the patient more time. More than 80% of physicians in the present study reported that consultations involving distress at work are longer than usual. A large-scale quantitative and qualitative study conducted by the Technologia consultancy under the auspices of the UMC health insurance company in 2012, entitled "*Les effets du travail sur la vie privée*" (Impact of work on private life) sought to understand and, if possible, measure the impact of working life on private life, in all dimensions: social life, family life, love life, and sex life. Work monopolized daily life for 50% of employees (and 61% of executives), ahead of family life (30%), the life of the couple (17%) and social life (3%). According to Technologia, most employees are torn between the importance they give to their work and the importance they struggle to give to their private life, and family life in particular: working time tends to creep up on the rest. In the present

353 study, most patients reported history of distress going  
354 back several months or even years. By initiating more  
355 systematic dialogue about their patients' work, GPs  
356 could help improve prevention of occupational risk,  
357 in teamwork with the occupational physician.

358 Most patients in the study were expecting sick-  
359 leave, which all were accorded, for less than two  
360 weeks in most cases. It seems to be essential to get  
361 away from work and its anxiety-inducing environ-  
362 ment so as to be able to take some distance. Sick-leave  
363 duration varies with the severity of distress. A burnout  
364 prevention guide was drawn up by researchers and  
365 field experts in collaboration with the INRS (*Instit-*  
366 *tut National de Recherche et de Sécurité*: national  
367 research and safety institute) and ANACT (*Agence*  
368 *Nationale pour l'Amélioration des Conditions de*  
369 *Travail*: national agency for improvement in working  
370 conditions), advising 2–3 months' sick-leave associ-  
371 ated to psychotherapy. In reality, sick-leave averages  
372 between 6 and 18 months, according to Marie Peze,  
373 a Doctor of Psychology, psychoanalyst and expert  
374 witness who set up the first "distress at work" con-  
375 sultation in the Nanterre hospital reception and care  
376 center in 1997.

377 Several limitations of our study should be acknowl-  
378 edged. First, GPs participation was selective. GPs  
379 who volunteered to participate in the study could have  
380 been especially interested in mental health, however  
381 socio-occupational characteristics such as gender,  
382 seniority and working time did not differ between  
383 GPs answering the Order of Medicine survey and  
384 those including patients and responding to the study  
385 questionnaire. The GP response rate could have been  
386 increased by repeated reminders. The requirement  
387 to include only patients consulting for mental dis-  
388 tress at work for the first time limited the number  
389 of inclusions, but reduced selection bias. The use of  
390 the same questions in the Order of Medicine survey  
391 and in the study questionnaire allowed sample rep-  
392 resentativeness and the rate of GP consultation for  
393 mental distress at work to be assessed. A patient  
394 selection should also be considered, however the  
395 physicians participating in the study were instructed  
396 to ask all eligible patients to participate in the study.  
397 A third limitation was to do with the definitions of  
398 work-related psychiatric disorders: the attribution of  
399 work-relatedness makes by the GPs or the patient  
400 is subjective. For the measurement of GP-diagnosed  
401 psychiatric disorders, there were no standardized pro-  
402 cedures for the diagnosis. This could have introduced  
403 bias in the measurement however in France GPs do  
404 not use standardized procedures to establish diag-

noses of psychiatric disorders among their patient. 405  
Besides we have to cautious about the results because 406  
of the small sample size which does not allow the 407  
results to be generalized to the French population. 408

## 5. Conclusion 409

In the present study, most GPs in the Loire area 410  
reported difficulties in dealing with distress at work. 411  
Screening for the impaired physical and/or psycho- 412  
logical health status in case of distress at work 413  
reported by the patient should guide the GP's clin- 414  
ical approach. It is not the GP's role to establish a 415  
link between symptoms and work. The slowness of 416  
reaching a diagnosis of mental distress at work is a 417  
real problem: it is alarming to find that patients wait 418  
several weeks or even years before consulting their 419  
GP, despite experiencing impact on family life and 420  
health. For preventive purposes, the factors underly- 421  
ing such complaints need to be clarified. Referral to 422  
occupational medicine could be improved by improv- 423  
ing communication between patient and GP. It should 424  
be borne in mind that all employees have the right to 425  
ask for a consultation with their occupational physi- 426  
cian [17]. The present study highlights the importance 427  
of reporting negative experience of working condi- 428  
tions and impaired mental health to the occupational 429  
physician, so that he or she can undertake preventive 430  
measures. 431

## Conflict of interest 432

The authors declare that they have no competing 433  
interests. 434

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