MOBBS TRAVELING FELLOWSHIP AWARD TO ATTEND THE 29TH INTERNATIONAL CONGRESS ON OCCUPATIONAL HEALTH IN CAPE TOWN, SOUTH AFRICA: A REPORT ON MY LEARNING EXPERIENCE

(DR ADENRELE ADEODU)

Introduction

I attended the 29th International Congress on Occupational Health in Cape Town, South Africa, in March 2009. The purpose of attending the congress was for me to orally present an abstract of my MSc/MFOM dissertation on occupational physicians' attitudes towards evidence-based guidelines (EBG) and evidence-based medicine (EBM).

Background

My research

In 2007/2008 I performed a cross-sectional postal questionnaire survey of 357 randomly selected members of the Society of Occupational Medicine. The aim was to identify barriers that may affect the implementation of occupational health EBG in the UK. The participants were asked about their attitudes towards evidence-based guidelines, the information resources they use to answer clinical problems, what prevents them from practising EBM, and their access to the Internet at work. The response rate was 73%.

My learning objectives for the ICOH congress

I had the following learning objectives:

1. To share the findings of my study with an international audience.
2. To learn about how occupational physicians in other countries are dealing with barriers to implementing EBG.
3. To learn about the role that EBM plays in occupational health in other countries.
4. To identify research opportunities in the development and implementation of EBG.
5. To network with other researchers interested in the field of EBM in occupational health.
6. To learn about current trends in occupational health.

The Congress

Theme

The theme of the 2009 congress was 'occupational health- a basic right for all and an asset to society'. The importance of evidence-based occupational health practice and interventions was emphasised throughout the congress; for example in the development of basic occupational health services and health promotion programmes.

A blast from the past

All the delegates were given a new English translation of Bernardino Ramazzini's work, "De Morbis Artificum Diatriba". I found some interesting observations within his commentary on sedentary workers. Firstly, Ramazzini describes a procession of tailors at a funeral, all of them bent, stooped and swaying. He attributes their sorry appearance to long hours of sedentary activity with poor posture. I wonder if they had thoracic spine fractures secondary to osteoporosis caused by lack of weight-bearing exercise? Secondly, Ramazzini advised that sedentary workers should exercise their bodies to avoid becoming weak, bent, and stooped. This was all the way back in the 17th century and still rings true today. I see it as a forerunner of current day health promotion programmes. I cannot agree more with Professor Rantanen's (ICOH president) exhortation for us to follow in the footsteps of Ramazinni, the founding father of modern-day occupational medicine. My copy of "De Morbis Artificum Diatriba" is set to be well-thumbed!

Sharing my research findings with an international audience

I gave a 10-minute oral presentation of my study, the findings, and the implications for evidence-based occupational health practice. The main points of the presentation were:

1. The doctors who participated in my study were generally positive towards EBG, although 1 in 4 of them also had negative attitudes. Some of the negative attitudes, such as the beliefs that EBG reduce physicians' autonomy and that they are too rigid to apply to individual patients, are probably due to a misunderstanding of the actual concept of EBM. The definition of EBM is that it is 'the integration of the best available research evidence with our clinical expertise and the unique values and circumstances of our patients.'

2. Almost all the doctors in this study had access to the Internet in their workplaces. When faced with a clinical problem for which they needed to search for an answer, 90% of them would ask a professional colleague and 76% of them would use Google. Less than 20% of them would use the NHS Plus or Cochrane Occupational Health Field websites. There is a need to bridge this gap.

3. The doctors in this study reported lack of time as the commonest barrier to practising evidence-based medicine. Their statements suggest that this is due to a combination of factors such as busy clinics and high business demands, inefficient search strategies, and too much information in some sources of EBM.

4. Educational and training programmes could be developed to improve UK occupational physicians' awareness and use of the NHS Plus and Cochrane Occupational Health Field websites. The programmes could also help UK occupational physicians improve and maintain their EBM skills.

5. Occupational physicians' jobs should be designed to give them sufficient time to practise EBM and use EBG.

6. The guideline developers should continue to include summaries of the key points so that clinicians can use them more easily in busy clinical settings.

In my opinion, the presentation went well, although it would have been helpful if the conference organisers had given the audience a chance to provide written feedback about individual presentations.

Barriers to EBM in occupational health in other countries

Most of the research on this has been performed by a team at the Coronel Institute in the Netherlands. Their research suggests that occupational physicians find it hard to practice evidence-based medicine because they use poor search strategies. These researchers believe that education and training is a key tool to deal with this. Their recommended strategy is that occupational physicians should begin by searching for EBGs, where they exist, which are at what they describe as the 'apex' of the 'EBM pyramid'. They argue that EBGs are the most time-efficient information resources because the task of searching for **all** the best evidence and appraising it has already been done for the reader.

The role of EBM in occupational health in other countries

There is a strong body of evidence, especially from the USA and Holland, that well designed and integrated health promotion programmes and preventive interventions yield cost benefits.

Evidence-based medicine in occupational health- research opportunities

Following discussions with other researchers, I believe there is still scope to use psychological theories of planned behaviour to study the barriers that prevent occupational physicians from practising evidence-based medicine. Additionally, if an EBM training course

is developed for occupational physicians in the UK, its effectiveness could be assessed by testing their attitudes and knowledge before and after the course.

One researcher had studied the cost effectiveness of EBG adherence by comparing duration of sickness absence amongst cases in which a national mental health guideline had been used to those in which the guideline had not been used. There was no difference and it was felt that this was probably because there was considerable overlap between practice in the guideline and non-guideline groups. This highlights the difficulty in demonstrating cost effectiveness of using evidence-based guidelines and is an area where further research is required.

Networking with other EBM researchers

I met with key researchers in the field of EBM in occupational health, many of whom had written the studies I referred to in my dissertation. I also met a few other researchers and we exchanged contact details. I was able to help other researchers interested in evidence-based occupational health practice by sending them a key reference from my study. I intend to keep in touch with the colleagues I met because they will probably be a source of information and ideas for further EBM research, innovative ways of providing good occupational healthcare, and improving the quality of service I provide to customers and clients.

Current trends in occupational health

Social justice

Social justice was a key theme of the conference. Sir Michael Marmot gave a keynote address on social injustice and the determinants of health. There is evidence of increased mortality in the poorest people compared to people living above the poverty line. This gradient is also observed between social classes in the developed countries. The most vulnerable workers are the least likely to have access to an occupational health service. The long-term unemployed and workers who have temporary contracts have a higher mortality than those in employment with long-term contracts.

The changing world of work

Changing demographics, a global economy, and the current economic crisis present many workplace challenges to the 21st century occupational physician.

Lower birth rates and improved healthcare have led to a higher proportion of older workers (age 50 years and above). Although these older workers bring valuable attitudes, skills, and experience to the workplace, they are also more likely to have chronic health problems and may not be as mentally and physically agile as their younger colleagues. Good job design and matching, evidence-based health promotion (for instance, physical activity), and ergonomic interventions can mitigate these vulnerabilities and enable older workers to make a valuable contribution to national and global economies.

The global labour market has created an influx of migrant workers in developed countries. This group of workers often end up in poorly paid and unregulated jobs. They are some of the most vulnerable workers and yet they are the least likely to have access to occupational health services. As a result, they are at high risk of workplace injury, work-related morbidity and mortality.

The developed countries continue to move away from manufacturing and towards service provision. This shift brings the hazards of sedentary work and use of display screen equipment.

Rapid technological advances have also created new hazards such as nanotechnology.

Health promotion and integrated wellness programmes

Obesity, chronic pain, and common mental health problems are linked with presenteeism and reduced productivity. The economic costs of presenteeism are just as substantial as sickness absence. Presenteeism remains a hidden problem to many businesses even though there is a validated tool to measure it (Stanford Presenteeism Scale). Properly designed wellness programmes can reduce obesity and improve mental wellbeing with demonstrable cost benefits in terms of lower rates of presenteeism and sickness absence.

I learnt how occupational physicians in The Netherlands have successfully used motivational interviewing to increase physical activity amongst workers participating in a health promotion programme. This is a model that I am keen to explore and develop when I become a consultant occupational physician.

Basic occupational health services

There were interesting presentations on the organisation and delivery of basic occupational health services (BOHS) and case studies of implementing BOHS. The principle of BOHS is provision of occupational health for all workers across the world.

Making the business case for occupational health

I attended an excellent presentation by Richard Heron on how occupational health practitioners can justify occupational health programmes to business managers. This has given me a good understanding of how I can explain the benefits of implementing an occupational health programme in terms of direct and indirect costs to the business. It has also given me more insight into identifying the health needs of an organisation and aligning these needs with the organisation's goals and overall strategy. Finally, I feel confident about identifying appropriate measures by which the effectiveness of occupational health interventions can be demonstrated in business language.

Economic impact of OH activities

The National Institute for Occupational Safety and Health (NIOSH) in the United States has developed a model for predicting the economic impact of implementing preventive actions in the workplace. The model was developed by an economist and is rather complex. NIOSH hopes to make it available later this year.

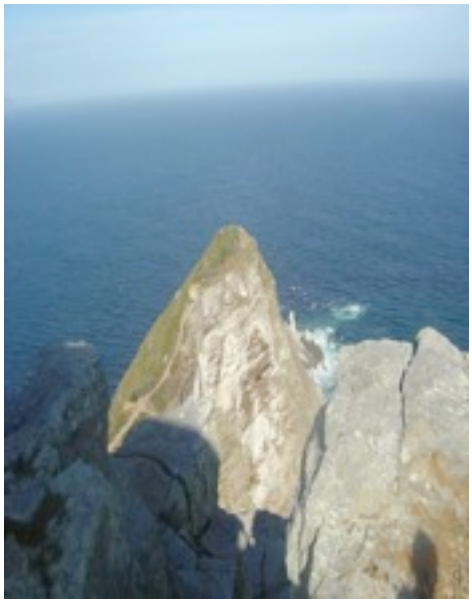
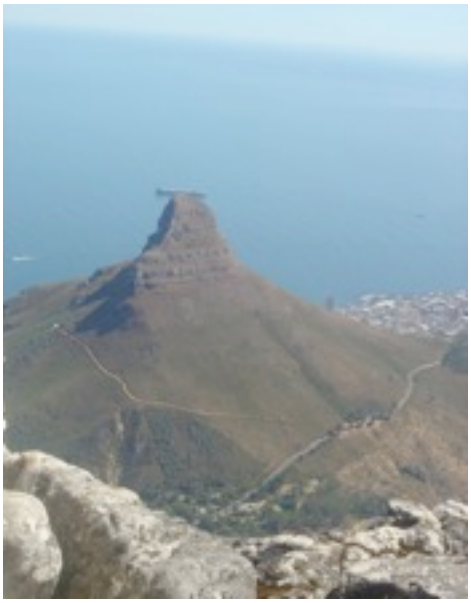
Stepping out

It was not all work at the ICOH. My taste buds received their fair share of CPD points in some brilliant restaurants that I visited with other delegates. I also managed to visit Table Mountain and Cape Point both of which literally took my breath away with their rugged beauty.

Here are some pictures.

Picture 1: Cape Point

Picture 2: Lion's Head as seen from Table Mountain

Conclusion

To sum up, this was a fantastic learning experience for me. I have come away with a renewed commitment to the ICOH, ILO, and WHO goal of providing high quality occupational health services to all workers. The congress has given me ideas for further research in evidence-based occupational health practice. It has also stimulated my interest in preventive occupational health and the improvement of workplace health and productivity.

I am grateful to Corporate Health and the Faculty of Occupational Medicine for granting me such a great opportunity. I would also like to thank NHS Plus for funding my research, and Dr Ira Madan and Professor Raymond Agius for guiding and supporting me.

SigPlus1 Signed to: Pages 1 - 5

Sat Apr 2009 04/04/09 16:08:05

Dr Adenrele Adeodu MB ChB MRCP (UK) AFOM MSc (Occ Med)
Specialist Registrar in Occupational Medicine
Capita Health Solutions