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SICKNESS CERTIFICATION WHEN EXPERIENCED AS PROBLEMATIC BY PHYSICIANS

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Mätarlarven

Jag sträcker mig ut från mitt körsbärsblad
och spanar mot evigheten:
evigheten är alldeles för stor idag,
Alldeles för blå och tusenmila.
Jag tror jag stannar på mitt körsbärsblad
och mäter upp mitt gröna körsbärsblad

Werner Aspenström
Ur Litania 1952

ABSTRACT

Background and aim: Physicians play an essential role in the sickness absence process, and many of them experience related tasks as problematic. The overall aim of this thesis was to improve the understanding of sickness certification experienced as problematic by physicians in general practice and occupational health services, and to gain more knowledge about the frequency and severity of those problems.

Materials and methods: Four studies were conducted, two of which were based on written cases reports, one on discussions of those reports, and one on questionnaire data. Courses intended to improve sickness certification practices for physicians in general practice and occupational health services were held in different parts of Sweden. Before taking part in such a course, the physicians were to send in a case report describing one of their own problematic sickness certification cases. During the courses, these cases were considered in group discussions. In the first study, dilemmas experienced by the physicians regarding their problematic cases were identified. The research material that was analysed consisted of some 100 documented names of dilemmas obtained from five courses, and the analytical method used was a descriptive one-step categorisation. In the second study, the main characteristics of 195 written case reports from nine courses were discerned by analysis using a stepwise descriptive categorisation and quantification. In the third study, 44 case reports were analysed with a narrative approach with elements from both thematic and structural analysis. In the fourth study, the material consisted of answers to a questionnaire that had been sent to all physicians in Sweden. The analyses included responses from 2,516 specialists in general practice regarding the frequency and severity of problems in sickness certification, and the frequency of approving unnecessarily long sick-leave periods for different reasons.

Results: Eight categories of dilemmas experienced by general practitioners were identified. Examples of these were “not the doctors’ pigeon” (when the patients’ problem was perceived as not being medical in nature), “diagnosis as disguise” (when there was a discrepancy between how the patient described the problems and what the physician apprehended), and “harmed by sick listing” (when the physician perceived that the main problem was the iatrogenic adverse effects of sick leave per se). In the analyses of the written case reports about problematic sickness certification, information on the following was often provided: age and sex, family situation, occupation, stressful life events, and medical investigations and treatments. Two thirds of the patients had been on sick leave for more than a year. It was found that the most common type of cases concerned women, who were employed in non-qualified nursing occupations and were on sick leave due to psychiatric diagnoses. Furthermore, the most common measures taken by the physician were referrals to a psychotherapist and/or physiotherapist, and prescribing antidepressants. In their written case reports, physicians described clearly different ways to relate to the problems they faced, and five “types of message” were identified. A common feature of the case reports was a striving for neutrality, and that the patients’ stories tended to be interpreted within a traditional biomedical frame. The physicians’ personal and emotional involvement and their relations with the patient were visible to varying extents. Overall, the responses

were about having problems as such, rather than the specific features of the problems. According to the national survey about frequency and severity of problems, general practitioners considered assessments of work capacity to be very or fairly problematic. Other problems reported in this context were related to the following: handling situations in which the physician and the patient had different opinions about the need for sick leave, and managing the dual roles as both treating physician and medical expert when writing certificates to be used by the social insurance office. At least once a month, a majority of the physicians issued sickness certificates for longer periods than they deemed necessary, often due to waiting times in health care and in other organisations. Younger and male specialists more often reported doing this in order to avoid conflicts with the patients.

Conclusions: The tasks involved in sickness certification challenge the physicians' professionalism in certain ways, and several related problems are reported to be both frequent and severe. Cases perceived as problematic have several characteristics in common. Some of the problems were more closely related to consultations and typical situations in which the physician had difficulties in acting in accordance with his or her sense of what was the right thing to do, primarily due to conflicting demands or loyalties.

Key words: sick leave, sickness certification, general practitioner, occupational health, physician, family practice, narrative, consultation, health care

SAMMANFATTNING

Bakgrund och syften: Läkarna har en viktig roll i sjukskrivningsprocessen och många läkare upplever uppgifter som ingår som problematiska. Det övergripande syftet med den här avhandlingen var att öka förståelsen för på vilket sätt läkare som är verksamma inom primärvård och företagshälsovård upplever sjukskrivningsärenden som problematiska, samt att få mer kunskap om frekvens och svårighetsgrad av sådana problem.

Material och metoder: Fyra studier har gjorts av vilka två baseras på skriftliga fallbeskrivningar, en på diskussioner kring dessa fall och en på data från en enkät. Kurser i försäkringsmedicin för allmänläkare och företagsläkare arrangerades på olika platser i Sverige. Före kursen skulle varje kursdeltagare skicka in en beskrivning av ett eget problematiskt sjukskrivningsfall. Under kursen hölls diskussioner och rollspel kring dessa fallbeskrivningar. I den första studien identifierades dilemman som läkarna upplevde i sina problematiska fall. Forskningsmaterialet utgjordes av 100 dokumenterade namn på dilemman från fem olika kurser och analysmetoden var en kvalitativ kategorisering i ett steg. I den andra studien identifierades väsentliga karaktäristika i fallbeskrivningarna. Materialet utgjordes av 195 fallbeskrivningar från nio konsekutiva kurser och dessa analyserades med stegvis deskriptiv kategorisering med inslag av kvantifieringar. I den tredje studien analyserades 44 fallbeskrivningar med narrativ ansats med såväl tematisk som strukturell metod. I den fjärde studien bestod materialet av svaren på en enkät som hade skickats ut till alla läkare i Sverige. Analyser gjordes på svaren från 2516 specialister i allmänmedicin avseende frekvens och svårighetsgrad av problem i sjukskrivningsärenden och likaså frekvensen av onödigt långa sjukskrivningar av olika skäl.

Resultat: Åtta olika kategorier av dilemman identifierades. Några av dessa var “Inte doktorns bord” (när problemet uppfattades som i grunden icke medicinskt), “Diagnos som dimridå” (när det fanns en diskrepans mellan hur patienten beskrev sina problem och vad läkaren uppfattade i konsultationen) och “Sjukskrivningsskadad” (när läkaren uppfattade att det huvudsakliga problemet var de skadliga effekterna av sjukskrivningen i sig). I de skriftliga fallbeskrivningarna beskrevs ofta följande faktorer; ålder, kön, familjesituation, yrken, stressande livshändelser, medicinska utredningar och behandlingar. Två tredjedelar av patienterna hade varit sjukskrivna i mer än ett år. Den vanligaste typen av fall handlade om kvinnor, anställda i okvalificerade vårdyrken och sjukskrivna på grund av psykiska problem. Läkarens vanligaste åtgärd var att remittera till samtalsterapi och/eller sjukgymnast samt att förskriva antidepressiva. Ett genomgående drag i fallbeskrivningarna var en strävan efter neutralitet i såväl innehåll som form och att patientens problem tolkades inom en biomedicinsk ram. Läkarens personliga och känslomässiga engagemang samt relationen till patienten framträdde i olika grad. Läkarna hade olika sätt att förhålla sig till problemen och fem olika ”typer av budskap” identifierades. Genomgående var att budskapen handlade om det faktum att man hade ett problem, snarare än om karaktären av problemet i sig. Ett vanligt förekommande problem bland specialisterna i allmänmedicin, vilka besvarat den nationella enkäten, var att bedöma patientens arbetsförmåga. Andra typer av problem var att hantera situationer där läkaren och

patienten hade olika åsikter om behovet av sjukskrivning och att hantera de två rollerna som patientens behandlande läkare och medicinskt sakkunnig inför Försäkringskassan och andra myndigheter. En majoritet sjukskrev längre än vad de själva ansåg vara nödvändigt åtminstone någon gång per månad, framförallt på grund av olika väntetider, och yngre och manliga allmänläkare svarade oftare att skälet var att undvika konflikter med patienterna.

Slutsatser: De uppgifter som läkarna har i sjukskrivningsprocessen utmanar läkarens professionalitet på olika sätt och vissa problem är både vanligare och svårare än andra. De fall som uppfattades som svåra har flera karaktäristika gemensamt. Vissa problem uppstår i själva konsultationen och i typiska situationer där läkaren har svårt att följa sin känsla för vad som är rätt, ofta beroende på motstridiga krav och lojaliteter.

LIST OF PUBLICATIONS

I. Engblom M, Alexanderson K, Englund L, Norrmén G, Rudebeck CE. When physicians get stuck in sick-listing consultations: a qualitative study of categories of sick-listing dilemmas. Work. 2010 Jan;35(2):137–42.

II. Engblom M, Alexanderson K, Rudebeck CE. Characteristics of sick-listing cases that physicians consider problematic-analyses of written case reports. Scandinavian Journal of Primary Health Care. 2009;27(4):250–5.

III. Engblom M, Alexanderson K, Rudebeck CE. Physicians' messages in problematic sickness certification: a narrative analysis of case reports. BMC Family Practice. Accepted 2011.

IV. Engblom M, Nilsson G, Arrelöv B, Löfgren A, Skånér Y, Lindholm C, Hinas E, Alexanderson K. Frequency and severity of problems general practitioners experience regarding sickness certification (Submitted 2011).

CONTENTS

LIST OF ABBREVIATIONS

GP	general practitioner
PHC	primary health care
OHS	occupational health services
SIO	social insurance office
OR	odds ratio
CI	confidence interval

PROLOGUE

General practice has been my speciality and profession for over twenty years, and meeting patients and colleagues is a daily challenge and joy. Becoming more experienced over time is restful in some senses, but in other senses the challenges that both my co-workers and I myself must face in practice have become more visible. These include handling patients with diffuse symptoms and managing the expectations of, and in some cases even conflicts with, the patients.

From the middle of the 1990s, the rates of sick leave rose markedly in Sweden. At that time, I started my work as a general practitioner (GP) in a suburb of Stockholm. Many of the inhabitants were well educated, they were busy with their jobs and families, and they had high expectations about a diagnosis and treatment when they came to see me. Many complained about fatigue and stress, and I found it remarkable that so many had the same kind of symptoms. A large proportion of them wanted sickness certificates, and I said to myself that actually there ought to be some kind of explanation for all of this. Could there be an association with the heavy power line that crossed the community? I even thought that this must be some new kind of "syndrome". Later on I realised that this rise in the rates of specific types of illnesses was the same as in many other communities in Sweden at that time.

At the beginning of this millennium, I was asked to teach courses aimed at improving physicians' skills in sickness certification. From the start, these courses were for GPs only, but, after some years, they were offered to a broader group of physicians. In all, about a thousand physicians participated, and each of those wrote a case report about their own problematic cases involving sickness certification.

The number of sick leave cases continued to grow and along with that also my curiosity regarding what this problem was all about. I wanted to know what kinds of cases were perceived as problematic and also in what way physicians had difficulties in handling them. I also wanted to learn more about the physicians' role in the sickness certification process. Fortunately, I met inspiring and supportive colleagues, both course participants and fellow teachers, and I was encouraged to investigate this matter. That was the point of departure for my research.

1 BACKGROUND

The first section of this chapter provides a brief description of the health care system in Sweden and also the work of GPs at primary health care (PHC) centres and physicians in occupational health services (OHS). After that, physicians' sickness certification practices are described by giving a short historical overview of the sickness insurance system and the present regulations. To reflect on the physician's role in this system, remarkable variations in rates of sickness absence are reported, and thereafter the physicians' tasks in the present system in Sweden are described. Furthermore, the concept of consultation is defined, and an account is given of the type of problems that can arise in any consultation as well as in those when sickness certification (the synonym sick-listing will sometimes be used) is a possibility. Next, the area of research is explained, along with the rationale for this thesis. Finally, the perspective taken is clarified.

1.1 PRIMARY HEALTH CARE

All people living in Sweden have the lawful right to seek health care. There are in-patient hospital treatments and out-patient treatments in open units such as PHC centres. The size of those centres varies, and their task is to provide basic health care. Most of the physicians at PHC centres are board-certified specialists working as GPs after completing five years of resident training after undergraduate education and internship (in all, at least twelve years of education and practice). The GPs often work in teams together with nurses, laboratory personnel, physiotherapists, psychotherapists, and others, but the majority of the patients that attend a PHC centre meet only a GP.

OHS in Sweden can be organised in different ways. Some units are closely related to one company, whereas others have agreements with several employers. Some of the OHS units offer health care, but others are restricted to regular health check-ups for employees. Many OHS physicians are board-certified specialists, usually in general practice, but that is not a formal requirement for such posts.

1.2 SICKNESS CERTIFICATION

1.2.1 History and present regulations

In Sweden, the first type of voluntary sickness insurance for groups of employees evolved about a hundred years ago and was available mainly for workers performing heavy manual labour (1, 2). The occupational group itself was responsible for ensuring that the right people benefited from the insurance. In 1947, Sweden enacted the first legislation concerning a public insurance for sickness absence (3). Then, as now, a physicians' certificate was required to show that a person's work capacity was reduced due to disease or injury.

As in most other Western countries, patients in Sweden must obtain a medical certificate issued by a physician before they can be granted benefits (4), and such a document is required after one week of absence. The sickness certificate is to include

information about the following: the medical condition, in what way that condition affects function and work capacity, treatment and other measures needed, and the duration and degree of absence. The employer, or after the second week the Social Insurance Office (SIO), decides whether a person fulfils the criteria for sickness benefits (4).

In 2007, the Board of Health and Welfare introduced national guidelines to be used by physicians in the management of sickness certifications (5). Furthermore, in 2008, stricter interpretation of laws and regulations was adopted with regard to for how long sickness benefits could be granted (in Swedish *rehabiliteringskedjan*).

1.2.2 Sickness absence rates

In three Western countries—Norway, the Netherlands, and Sweden—sickness absence rates increased distinctly in the middle of the 1990s and began to decline about ten years later (6). Fair comparisons cannot easily be done between countries, since important factors effecting this, such as social security systems, age for old-age retirement, employment frequencies etcetera, differ (7). However, levels of sickness absence are still high in several industrial nations, and the vast proportion of sick-leave spells is due to musculoskeletal or psychiatric diagnoses (8-12). In Sweden, from the end of the 1990s to the beginning of the 2000s, sickness absence rates more than doubled (11) (Figure 1), and the greater part of the increase was due to a rise in long-term sick-leave spells (> 59 days).

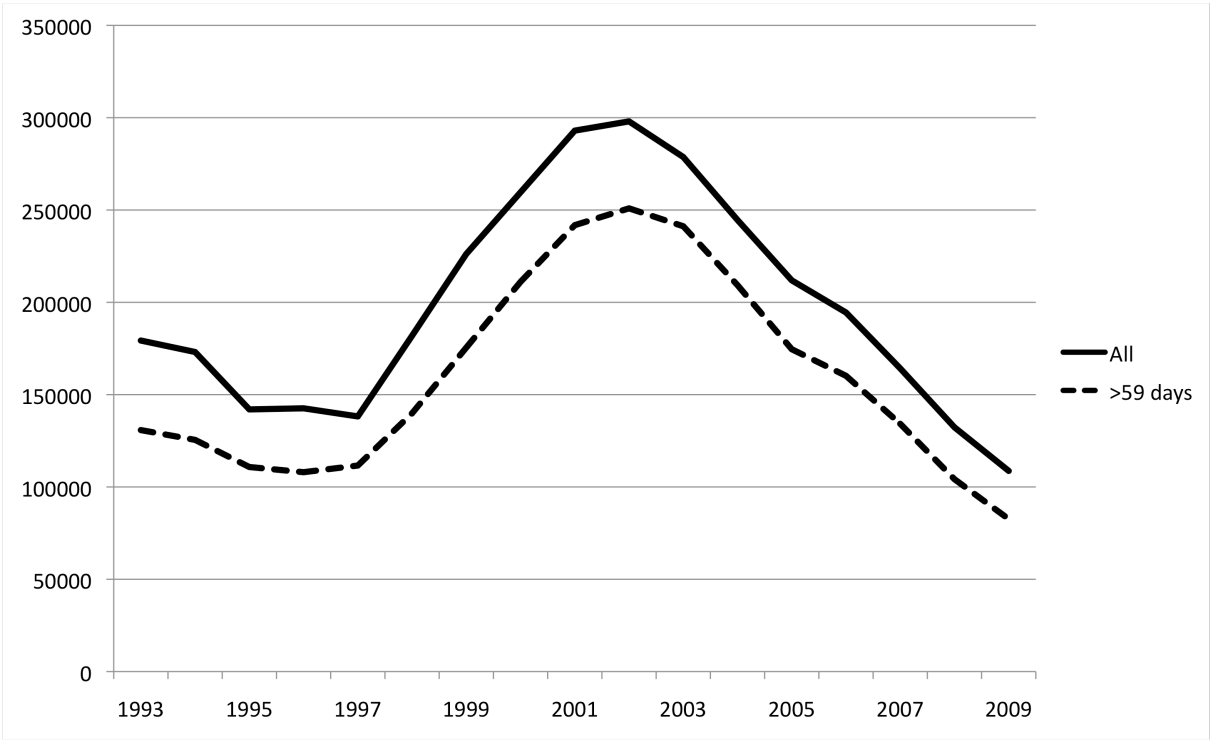


Figure 1 Number of all sick-leave spells and sick-leave spells > 59 days, respectively, in December each year (1993–2009). Data from the Swedish Social Insurance Agency (6).

The major changes in sick-leave rates over a short period of time in Sweden (Figure 1) indicate predominantly non-medical explanations for the fluctuations. Several researchers have suggested reasons for this phenomenon, mostly related to changes in work environment and defective rehabilitation measures of employees (13, 14). Others claim that the modern way of living can affect individuals' experiences and attitudes towards work, illness, diseases, and sickness absence (15). As an illustration, a Swedish questionnaire study among public employees in 2001 revealed that 48 percent considered having family problems to be an acceptable reason for sickness absence (16).

Sickness absence due to diagnoses that are characterised by diffuse symptoms, like pain, and tiredness, are often referred to as cultural diseases (17). The prevalence of those problems varies from time to time. An example of such a disease is fibromyalgia, which some researchers doubt is a distinct medical entity (18). Another example is myalgic encephalopathy, which is characterised by severe fatigue without a distinct biomedical explanation; this condition has higher prevalence in some countries, and it is also the subject of much disagreement and uncertainty (19).

Whatever the explanations for the varying sick-leave rates, sickness certification for non-medical reasons contributes to medicalisation (20). Physicians are part of the process, responding to the variations in demand for sickness certification.

1.2.3 The physician's tasks in sickness certification

In Sweden, as in most countries, sickness certification consultations involve a number of tasks for the physician (8), among other things to determine whether the patient has a disease or injury, and to assess whether the disease/injury impairs the patient's functional and work capacity. Furthermore, the physician, together with the patient, is to consider the advantages and disadvantages of sick leave and also the duration and degree of such absence. Moreover, the physician sometimes needs to cooperate with others, inside and outside health care, and issue a certificate. Lastly, any measures taken have to be documented on the sickness certificate and in the patient's medical records. To manage these tasks requires certain competence, including formal knowledge and skills in aspects such as communication and decision making (21).

During the last decade, the Swedish Board of Health and Welfare made it clear that sickness certification is a part of treatment in health care (22), implying that such certification, as well as various other treatments, can have different types of negative "side effects" for the individual and that quality assurance of health care also should include how sickness certification of patients is managed. Some studies have shown possible negative consequences of being sickness absent (23-25) or of being on disability pension (26).

Frequencies of sickness certification consultations for individual physicians vary much between clinical settings. In 2002, according to one study of certificates coming to some Insurance Offices during a week, GPs issued 57% of the total number of sickness certificates, and the corresponding figure for physicians in OHS was 13% (27). In 2008, the proportion of physicians who had such consultations more than five times a

week was smallest in dermatology (3%), greatest in orthopaedics and occupational health services (79% and 78%, respectively), and 43% in primary health care (28).

1.3 CONSULTATIONS

1.3.1 Concepts used

The concept "consultation" can be defined in different ways. This thesis focuses on what happens when the physician meets the patient, and the definition given by James Spence is still applicable: "In the intimacy of the consulting room or sick room a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it" (29). Several models of this encounter can be found. In a traditional biomedical model, the consultation serves merely as the setting within which the physician does the diagnosing and treating. One of the first attempts to understand the more psychological aspects of the consultation was made by the psychoanalyst Michael Balint (30), and since then several other models have been formulated that are similar in their attempt to broaden the conventional medical approach (31-33).

A normative model of the consultation is one that is based on a theory about how certain components can improve outcome, often evaluated in terms of patient satisfaction (34, 35). A well-established normative model is "the patient-centred (as opposed to doctor-centred) clinical method". This model illustrates how the patient's agenda is placed in the centre by asking for a description of his/her beliefs, concerns, expectations, and feelings (33, 36). The method is designed to attain an understanding of the patient as well as the disease. The physician needs to elicit patients' ideas about their problems, their preferences for treatment, and their understanding of the responsibilities of both the doctor and the patient in management of care (37). Consultations according to this model tend to increase the degree of satisfaction among both physicians and patients (34, 35, 38). Also, patients' satisfaction is correlated with fewer diagnostic tests and referrals (39). However, the implications of a patient-centred model should not be mistakenly regarded as always complying with the patients' wishes, for example with respect to sickness certification.

1.3.2 Problems in consultations

It is inevitable that some consultations will be troublesome for physicians, regardless of whether they are or are not about sickness certification. Balint (30) described how important it is that the physician takes his or her time to listen to the patient. Among the problems that can otherwise arise, according to Balint, is that the physician (and sometimes also the patient) can be too fast in searching for a specific diagnosis, referring to other specialists, or writing prescriptions (e.g., for tranquillizers). An unfortunate consequence of this can be medicalisation of life conditions or other circumstances, as well as distrust in the consultation.

Using a sample of videotaped consultations, Arborelius et al. (40-43) investigated those in which the GP reported that he/she felt uncertain and did not grasp the situation. It was found that a factor contributing to the uncertainty was that the GPs did not fully

understand their patients' reasons for the consultations. Furthermore, a general finding was that the GPs did not allow themselves to use feelings of uncertainty as important information about what was going on.

Another researcher who has dealt with physicians' feelings in problematic consultations is Nigel Mathers (44), who wrote about "the heart sink patient", meaning a patient who evoked a sense of "angry helplessness" in the physician. A model for coping with such difficult patients was elaborated, which included sharing the difficulties with colleagues, developing boundaries, challenging one's own attitudes, confronting hopelessness, and accepting powerlessness.

1.3.3 Sickness certification consultations

In his textbook of family medicine, Ian McWhinney (45) describes challenges in the communication between doctor and patient. One of the most difficult things for a physician, in any kind of consultation, is to know what context to use in "decoding" the patient's message. McWhinney also writes about sickness certification as an example of a problematic consultation. If, for example, the patient in direct terms asks for a sickness certificate and the request is refused, he/she loses face. On the other hand, if asking for the sick note is an afterthought, refusal causes less embarrassment. In those cases when work incapacity is unclear, an ambivalent patient might try to convince both himself and the physician that his impairments are real (46). If the physician issues a sickness certificate against his or her own better judgment, distrust in the relationship is an inevitable consequence.

1.4 RESEARCH FIELD

1.4.1 Physicians' sickness certification practice

A systematic review of published studies established scientific evidence for that physicians experience sickness certification tasks as problematic (47), and this was confirmed by some later investigations (47-52). In Sweden, the odds ratio (OR) for finding sickness certification tasks problematic was found to be highest among physicians working in PHC (OR 3.3, 95% CI 2.93–3.72) and at rheumatology clinics (OR 2.6, CI 1.87–3.52), using internal medicine as reference (28); for physicians in OHS, the corresponding OR was 1.1 (CI 0.89–1.45).

Several tasks involved in sickness certification can lead to challenges for the physician. One such difficulty is the potential conflict between the two roles of being the patient's treating physician and the medical expert issuing certificates for the SIO (53-56). Also, many physicians find sickness certification more problematic when the decision has to be made more or less solely on the basis of the patient's own description of his or her symptoms (50, 57, 58). Furthermore, studies have shown that physicians report that they need more knowledge and skills in handling sickness certification (56, 59-61). Other problems that physicians experience are related to the assessment of work incapacity, estimation of length and degree of certification, and handling of conflicts with patients over sickness certification (47, 48, 56, 62-66). In addition, many physicians feel they lack support in handling these problems (62, 67, 68).

Physicians in all types of medical specialities share most of the problems experienced in sickness certification (8, 28, 47), and the differences that can be attributed to factors such as age or sex are few and vary between studies (49, 52, 69-72).

1.4.2 Physicians' actions in sickness certification

In a qualitative study conducted by Hussey et al. (50), in the United Kingdom it was shown that GPs develop individual ways of operating the sickness certification system, sometimes even implying a deliberate misuse. The physicians interviewed in that investigation felt that this occurred because the system failed to address complex, chronic, or doubtful cases. In line with that observation, a study performed by Lynöe et al. (73) in Sweden illustrated that loyalty to the social insurance system varied depending on the degrees of urgency and on the distress level of the patient. That investigation used case vignettes about patients who were having problems that obviously did not entitle them to sickness benefits.

Englund et al. found that physicians often acted contrary to their own beliefs when providing sickness certificates (74) and that they more often issued certificates to patients who actually demanded them than to those who did not (70). In contrast, Campbell et al. (75) observed that the physician's decision to offer a sick note was not influenced by the patient's demands. Both those studies were based on case vignettes, and it is possible that different wordings in those accounts affected the results.

Englund also studied sickness certification practices by conducting audits of GPs in Dalarna County in Sweden in 1996, 2001, 2007, and 2009 (74, 76, 77). The sickness absence rates in that county were slightly above the average national level during those years (11). Considering all consultations with patients, the proportions involving issuing of sick notes were 9%, 16%, 11%, and 9%, respectively. Whether the patient was granted a sickness certificate or not was registered. Over all the studied years, only a few percent of the consultations that involved consideration of sickness certification did not lead to issuing of a sick note. For cases in which the GP felt that sick leave might be harmful, or that he/ she should not have suggested sick leave, there was only a marginal increase in the numbers of consultations where a certificate was not issued. The transferability of the conclusions reached in these audit studies has been questioned by some researchers (78). However, there are no obvious reasons to presume that the GPs in Dalarna County differed from other Swedish GPs with regard to their actions in this context.

1.4.3 Rationales for the present research

Physicians, especially GPs, have an essential role in the sickness absence process (8, 47, 63). There is a lack of knowledge on different aspects of physicians' sickness certification practices, especially concerning the types of sickness certification cases that physicians actually experience as problematic and what factors contribute to the problems (8). The physician's potentially conflicting roles as both the patient's doctor and a medical expert who writes sickness certificates for other authorities (e.g., the SIO) is frequently reported as problematic (53-56). However, there are no models that

describe the specific quality of sickness certification consultations, and there is insufficient knowledge about how handling of sickness certification is perceived as problematic (79).

1.4.4 Perspective taken

Studies of sickness absence have been carried out from different perspectives (8), including those of society, the employer, the insurer, the physician, and the insured or sickness absentee (Table 1). The scientific discipline in this thesis is medicine, although in a broad sense, because it also includes the practice of medicine and especially what happens in the meeting between the physician and the patient in sickness certification consultations that are perceived as being problematic. The perspective taken is that of the individual physician or, more precisely, the GP and the OHS physician.

Table 1 How studies of sickness absence can be categorised (modified from Alexanderson and Norlund (8)) Bold type indicates the focus, perspective, discipline, and level considered in the present thesis.

Focus of the study	**Perspective taken in the study**	**Scientific discipline**	**Structural level of factors included in the analyses**
• Risk factors for sickness absence • Consequences of sickness absence • Promotion of return to work • **Professionals' sickness certification practices** • Methodological and theoretical development	• Insured individuals/sickness absentees/patients • Professionals (e.g., **physicians** or social insurance officers) • Employers • Health care • Social insurance offices • Local community Nation	• Epidemiology • Economy • Education • Law etc • Management • **Medicine** • Philosophy • Psychology • Public health • Sociology	• **Individual** • Organisational • Community • National • Global

2 AIMS

The overall aim of this thesis was to improve the understanding of sickness certification experienced as problematic by physicians in general practice and occupational health services, and to gain more knowledge about the frequency and severity of such problems. The specific aims were as follows:

-To identify categories of dilemmas experienced in the sickness certification practices of physicians.

-To discern common characteristics of case reports of sickness certification cases that physicians in general practice and occupational health services find problematic.

-To explore the meaning content of case reports about problematic sickness certification and specifically to look for possible messages to colleagues intended to read the reports.

-To further elucidate the frequency and severity of various problems that GPs experience when handling sickness certification of patients, and to determine how often and for what reasons GPs in some cases issue sick notes for longer periods than necessary.

3 THEORETICAL FRAMEWORK

In this chapter the framework of the present research with regard to context and fundamental concepts is described. It is assumed that the work conditions of all the physicians studied were equivalent, regardless of the type of workplace or employment. Furthermore, an account is given of the background of the researchers involved in the project, including their pre-understanding of the area of investigation.

3.1 GENERAL PRACTICE

According to McWhinney (45), one way to describe the essence of family medicine (the American denomination of general practice) is to describe the principles that govern the actions of GPs. One such principle is that these doctors are committed to the patient as a person rather than to a particular body of knowledge, group of diseases, or special technique. Also, the commitment of a GP is not limited by the type of health problem, and it has no defined end point. Furthermore, the GP seeks to understand the context of the illnesses, since many of them cannot be fully understood unless they are seen in their personal, family, and social context.

3.2 THE CASE REPORT AS A NARRATIVE

In this thesis, the concept "case" is used to indicate how the patient's problems are apprehended by a physician. Apprehending the patient is about classification of symptoms and signs, and also about empathy. McWhinney regards empathy as "the capacity to sense what it is like to be the patient: to experience illness, disability, depression and so on." (45). Thus, the "case" is about the patient and the patient's problem, but it also includes the physician's interpretations, more or less close to how things really are.

Here, the medical case report about problematic sickness certification is considered from a narrative perspective. In general, a narrative is a made up story, and the word comes from the Latin verb "narrare" which means "to recount". The field of narrative research is broad, including things like spoken language, texts, and pieces of art, and it is joined by an ambition to gain knowledge about the "story" per se or what type of messages it possibly conveys: "it interrogates both language and intention" (80).

In medicine, narrative research on texts can concern both the structure and the function of the texts in question. In a structural analysis, stories with similar factual content can be compared (81) with the aim of discovering similarities and differences in how the stories are presented. The most obvious content of a text does not always represent the most important aspect. Instead, other types of fundamental human experience can be transferred from one person to another (81). According to Labov and Waletsky (82), a complete narrative consists of the six elements presented in Table 2.

Table 2 The narrative elements proposed by Labov and Waletsky (82), adjusted

Element	Sub-element	Description
Abstract		What the story is about
Orientation		Relevant background information
Complicating action		Sequential clauses providing chronology necessary for a narrative
Evaluation		Why the story was told, and the storyteller's own opinions and values
	External evaluation	The storyteller expresses his or her opinion in explicit or implicit ways
	Internal evaluation	How the language is used to communicate values
	Comparators	Creating values by comparing what did and what did not happen
	Extension device	Connecting different episodes as if they were causally related
	Explications	The storyteller's explications of what happened
	Lexical signalling	Use of strong, clearly evaluating words
Resolution		What happened in the end
Coda		Final remarks outside the story

Another narrative approach is to conduct a thematic analysis (80). Here, stories as a whole are examined to discover their overall functions (83), such as to create identity (as a physician), to convey knowledge, to present a standpoint, or to ask for advice (80, 83, 84).

In the consultation, patients convey their thoughts and worries to the physician, who interprets what he or she has apprehended. In the book entitled "Doctors' Stories: The Narrative Structure of Medical Knowledge ", Kathryn M. Hunter (85) describes physicians' professional interaction with patients as an art that relies on interpreting the patient's story. One interpretation is the conventional medical chart, and another is the written case report, but, as Hunter puts it, these are "narrowly conceived and standardised by strict conventions of tone, plot and allowable detail" (85). Furthermore, inevitably integrated in the case report is its explicit or implicit message to the reader, most often a colleague. According to Hunter, one implicit goal is inter-subjectivity (85), which is described as a striving for a shared understanding from the colleagues reading the report. When perceived in this way, medical case reports can provide a rich material for research, despite Hunter's somewhat pessimistic general view.

3.3 PRE-UNDERSTANDING OF THE RESEARCH FIELD

The majority of the researchers involved in the present studies are board-certified GPs with a special interest in physicians' sickness certification practice. Most of us have also been employed at PHC centres for many years and are therefore familiar with the

work done at such facilities, including meeting patients with all types of health problems and the daily tasks involved in sickness certification. Four of us were also teachers at the sickness certification courses from which the material for three of the studies was collected. None of us has experience of work in OHS.

All the studies originated from the Division of Insurance Medicine at Karolinska Institutet, which is led by Professor Kristina Alexanderson, who has clinical experience as a hospital social worker and has educated physicians in insurance medicine and researched physicians' sickness certification practices over the last decades. The other researchers involved in the studies are all employed at that Division.

4 MATERIAL AND METHODS

This chapter begins with an introduction to rationales for the choice of methods employed to achieve the aims of the studies. Thereafter, the text presents descriptions of where, when, and how the research material was collected and the methods that were used in the respective investigations.

Table 4 Overview of the four studies included in this thesis

	Study I	**Study II**	**Study III**	**Study IV**
Aim	To identify categories of dilemmas experienced in the sickness certification practice of physicians	To discern common characteristics of case reports of sickness certification cases that GPs and OHS physicians find problematic	To explore the meaning content of case reports about problematic sickness certification, and specifically to look for possible messages to the colleagues intended to read the reports	To further elucidate the frequency and severity of various problems that GPs experience when handling sickness certification, and to determine how often and for what reasons GPs issue sick notes for longer periods than necessary
Study population	GPs who participated in sickness insurance courses in Sweden (n = 100)	GPs and OHS physicians who participated in sickness insurance courses in Sweden (n = 265)	GPs and OHS physicians who participated in sickness insurance courses in Sweden (n = 260)	All physicians in Sweden with a board speciality in general practice (n = 6,900) Response rate 59.9%
Years	2001–2003	2004–2005	2006–2008	2008
Study group/ Material	Case discussions from sickness insurance courses (n = 100)	Case reports from sickness insurance courses (n = 195)	Case reports from sickness insurance courses (n = 44)	GPs aged < 65 who had consultations involving sickness certification at least once a week (n = 2,516)
Main outcome	Categories of dilemmas experienced	Characteristics of problematic sickness certification cases	General qualities of case reports and type of messages to colleagues	Percentage of frequency and severity of problems experienced
Design	Cross sectional	Cross sectional	Cross sectional	Cross sectional
Analyses	Qualitative; descriptive categorisation in one-step	Qualitative; descriptive stepwise categorisation and quantification	Qualitative; descriptive categorisation with structural and thematic analyses	Descriptive statistics

4.1 RATIONALES FOR CHOICE OF METHODS

To obtain a better understanding of when and why physicians actually experience sickness certification as problematic, it is important to approach the thinking in practice. Qualitative methods are suitable for studies aimed at examining a phenomenon that is partly unexplored and also when the objective is to describe and elucidate that phenomenon. The qualitative methods used in the present research were developed in response to the character of the material (case discussions and case reports) in order to gain as much knowledge as possible. In the fourth study, quantitative analyses were applied using questionnaire data, because this added insights about the frequency and severity of experienced problems.

This thesis is based on the findings of four studies (I–IV) based on data obtained in Sweden in 2001–2008 (Table 4).

4.2 STUDIES I–III

4.2.1 Procedures

Courses aimed at improving physicians' sickness certification practices were held in different parts of Sweden. The first three-day course was for GPs only, and it was held in 2001 and arranged by the Foundation for District Medical Officers (In Swedish: *Provinsialläkarstiftelsen*) with financial support from the SIO. The first five-day-long course, arranged by the SIO, was held in March 2004, for physicians in general practice and OHSs.

Before taking part in a course, the physicians were to send in a written case report about one of their own consultations in which they "didn't feel comfortable with their sickness certification role". The report was to be about one page long.

Based on the case reports, short role-playing was done in groups comprising five to seven physicians. The physician who had contributed the case took the patient's role, and a colleague took the physician's role. After this, the group leader used a preset template to encourage the group members to investigate feelings and to give names to the dilemmas experienced. Thoughts about things like how to handle the case, possible alcohol abuse, and plans for meetings were also discussed, and everything was documented on flip charts.

4.2.2 Materials

The research material analysed in study I consisted of some 100 documented names of dilemmas from the first five consecutive courses held from October 2001 to April 2003 (Figure 2). All of the course participants were GPs.

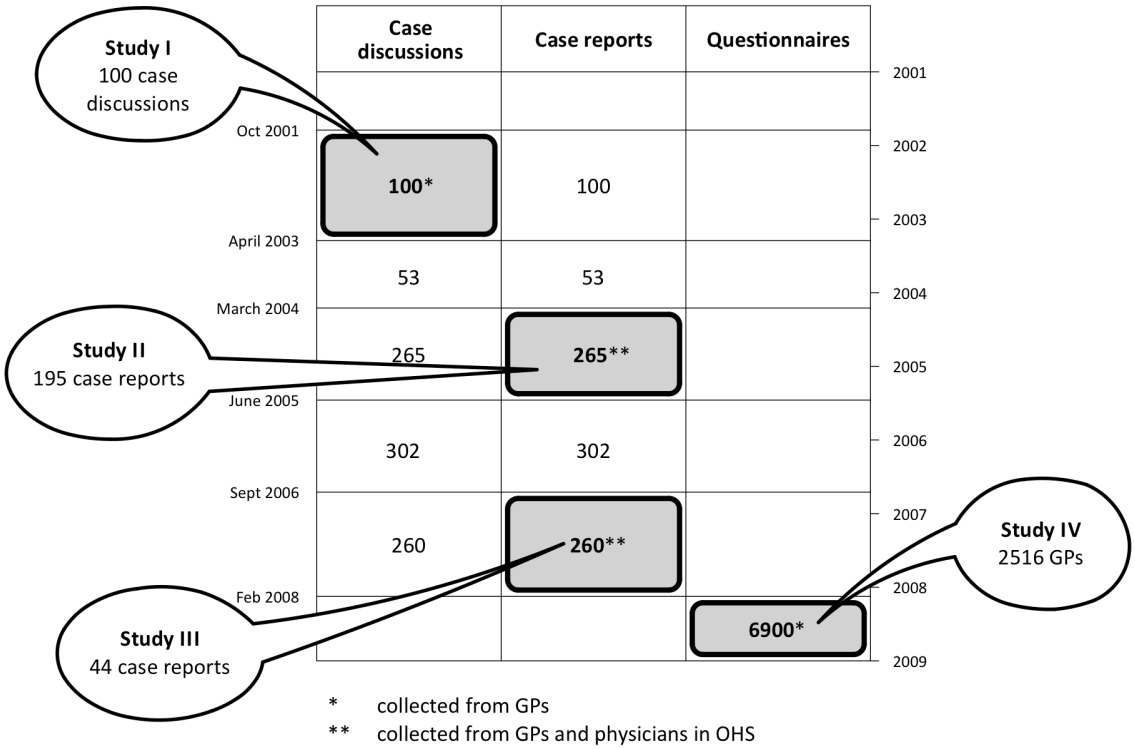


Figure 2 Illustration of the materials used in studies I–IV regarding what was collected, the study populations, and the study groups.

The research material for study II consisted of 265 case reports collected from nine consecutive sickness insurance courses arranged in different parts of Sweden from March 2004 to June 2005 (Figure 2); in all, 195 of those reports written by 195 different physicians were analysed. In study III, 44 case reports collected from ten consecutive courses held from September 2006 to February 2008 were analysed (Figure 2); 19 of the reports were used in the actual analysis and 25 for validation. In studies II and III, about half of the participants were GPs and the rest were OHS physicians.

4.2.3 Methods

The categorisation of the material collected for study I was conducted as a one-step qualitative analysis, which, in its simplicity, was still akin to the "editing style" described by Crabtree and Miller (86, 87). Primarily, the material was collected out of curiosity and without a definite plan for how to deal with it, although, in agreement with the pedagogic aim of the courses, there was an investigative approach. After a few courses had been held, the names of the dilemmas, according to their specific implications for the physicians, were categorised. This classification was done by discussing and systematising the material collected from the flip charts. Some preliminary categories were abandoned, and others were united into broader categories. An example of union of preliminary categories was that "existential problems as cause for sickness certification", "double messages", and "stuck in a safety net" were finally grouped together and called "diagnosis as a disguise".

In a final exercise in each course, all the case reports were categorised, and the course participants were invited to discuss the categories. One category that had not been thought of before (i.e., "sick-listing despite doubts") was added through this process. The categorisation was discussed continuously by the teachers, sometimes in connection with the courses and at other times via e-mail. The categorisation was concluded when no more dilemmas appeared that led to either modification of the existing categories or production of new ones. At this stage, the material was regarded as sufficiently saturated (88, 89), and the categories were considered to be stable.

The method used in study II was a stepwise descriptive categorisation and quantification. The case reports were studied in order to identify main causal conditions, and, inspired by Charles Ragin (90), this was done by looking for main characteristics shared by the cases. In terms of problematic sickness certification cases, a search for such main characteristics in their corresponding case reports would give insights into circumstances that tended to cause problems for the physician. First, all the case reports were scrutinised to identify and categorise facts that were always or often provided, and that in themselves constitute clearly defined categories (e.g., sex, age, occupation, and type of sick leave diagnosis). Thereafter, the case reports were subjected to more detailed and in-depth analysis to find categories of facts that were also provided directly, albeit not as frequently (e.g., country of birth and physical examination). In the last step, categories were created out of circumstances that were given in a more narrative way. Selection of the circumstances that were included was based on the researchers' pre-understanding of both frequency and relevancy, and the process of categorisation had traits common with the above-mentioned editing style described by Crabtree and Miller (86).

The method used in study III included a narrative thematic analysis (91) and a narrative structural analysis. The analyses of the case reports were performed along two parallel lines, one comprising a search for general qualities (thematic analysis) and the other a search for the contents of the narrative elements as proposed by Labov and Waletsky (82) (structural analysis), which agrees with the template style of qualitative analysis described by Crabtree and Miller (86). In a subsequent step, the results of the two analyses were combined to create a final comprehensive description of the narrative qualities and structural features of the case reports. The results were presented as "types of messages".

4.3 STUDY IV

4.3.1 Procedures

Data from a comprehensive questionnaire (92) sent to all physicians in Sweden were analysed in study IV. The total study population comprised the 36,898 physicians who lived and mainly worked in Sweden in October 2008. The questionnaire concerned physicians' sickness certification practices and it was developed based on previous investigations and a pilot study as well as on interactions with clinicians and other researchers (47, 48, 62). The questionnaire was distributed by mail to the participants' home addresses in order to avoid influence from colleagues during completion. Three reminders were posted to non-respondents. Statistics Sweden administrated the

questionnaire as well as drop out analyses, based on data from the company Cegedim, which also had information about the type of board specialist qualifications (after at least five years of resident training) from the National Board of Health and Welfare (28, 93). Statistics Sweden delivered the anonymous data to the research group.

4.3.2 Material

The material for study IV consisted of those 2,516 physicians (45% women) who had answered the questionnaire, were below 65 years of age, worked mainly in PHC, and had consultations involving sickness certification at least once a week. The overall response rate for GPs was 59.9% (n = 6,900). Thus, many physicians board certified in general practice did not mainly work as GPs. Some were administrators, or worked more with research and teaching than in clinical practice. Others worked in e.g. OHS. Several had more than one specialty.

Questions regarding experienced problems were asked to capture both frequency and severity of such problems. Some questions about problems were introduced with the phrase "How often in your clinical work do you….", and the participant could choose between six answers ranging from "More than 10 times a week" to "Never or almost never", which were categorised into three groups. The main question about experienced severity of problems was phrased "How problematic do you generally find it to …" followed by four response alternatives from "Very" to "Not at all" for each of the items listed. The third type of question began with "How often do you certify unnecessarily long sick-leave periods due to …", and the response alternatives ranged from "Every day" to "Never or almost never".

4.3.3 Methods for study IV

In study IV, answers to items about the following aspects were analysed: frequency and severity of problems, co-operation within health care, and frequency of medically unnecessarily long sick-leave periods. Descriptive statistics including estimation of p-values from Mann-Whitney tests were calculated.

5 ETHICS

In study I, the research material consisted of case discussions documented on flip charts. The names assigned to dilemmas were not linked to the individual case reports or to the contribution of individuals in the group discussions. As described in the methods section, initially the material was collected without a definite plan for how to deal with it, and the participating GPs were not asked for permission.

In studies II and III, the material investigated comprised physicians' case reports, and the participants were given identical written information about the research that was to be conducted. In Study II, the information was given either during a sickness insurance course or by e-mail. Eighteen of 265 physicians (Figure 2) rejected the invitation, and 52 (19.6%) never responded to the invitation, which, in their case, had been sent by e-mail after conclusion of the course. In study III, before the start of each sickness insurance course, written information about the study was provided, which requested the participants to indicate if they did not want their case report to be included in the study. None of the 260 participants (Figure 2) gave such an indication. The case reports were numbered to correspond with the list of course participants, and the individual physicians could not be identified in the presentation of the results.

In study IV, the research material consisted of answers from a national survey. Statistics Sweden had information about the study population for distribution of questionnaires and reminders. The research group had no access to that information, and the participants could not be identified in the presentation of results

All four studies were approved by the Regional Ethics Committee of Stockholm.

6 RESULTS

6.1 STUDY I

Eight categories of dilemmas experienced by GPs in connection with sickness certification were identified. Below, these categories are presented and illustrated by use of excerpts from case reports (collected from the researchers' own practice), which have been altered somewhat to ensure anonymity.

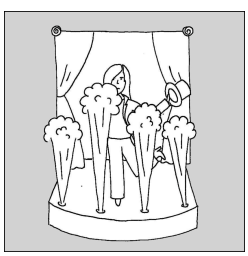
Not the doctor's pigeon In the group activities at the sickness insurance courses, the physicians often reported having feelings of irritation or frustration if they experienced that the reasons for sick leave were not primarily medical in nature. For example, a reason could be related to circumstances in the workplace, waiting times in health care and other organisations, or the patient's life situation as a whole, and sickness certification would still not solve the problem.

Erik *is 61 years old and suffers from shoulder pain. He is employed at a mechanical industry, where he already has adjusted work tasks. One week ago, upon arriving at work in the morning, he was ordered to work at a machine that he was not familiar with. This upset him, and he left the factory. Now, coming to the GP, he doesn't want to return to work. He has had trouble sleeping, and his stomach hurts.*

The doctor as servant The physicians felt frustrated and often provoked when a patient him-/herself or the circumstances in general almost forced them to provide a sick note, and their professional opinion was not requested.

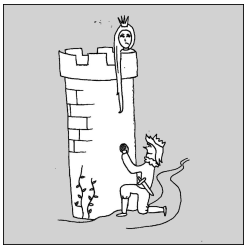
Kristina *is 54 years old, she is divorced, and has two teenage daughters. She works at a nursery school, 80% of full time. Now she has been informed that her working hours will be reduced to 50%, which will give her financial problems. She suffers from insomnia and from neck and shoulder pain. A trade union representative has told her to get a sick note rather than quit her job, and she has now come to the GP for that purpose.*

Diagnosis as disguise Here the physicians experienced a discrepancy between how patients described their problems and what was apprehended in the consultation. The patients were often more focused on what they could not do rather than what they were capable of doing, and they seemed to lack motivation for change. The physicians often experienced difficulties when handling a patient's request for sick leave.



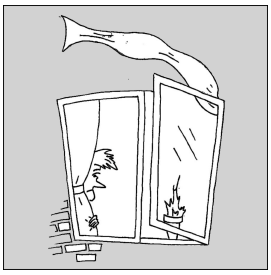
Marie *is 33 years old. She has recently moved to this town. She is single, has a son, and two large dogs. Her mother is on disability pension. Marie has been on sick leave for several years due to depression, fibromyalgia, and irritable bowel syndrome. She looks well kept and healthy. She now expects to be given a sick note by her new GP for still another period.*

Waiting for Mr Right Here the physicians felt somewhat uneasy, because investigations for health care services might have delayed assessments concerning the actual remaining working capacity. The patient might have had an unrealistic hope for a cure, and the physician's own anxiety about overlooking a real disease may have interfered with deciding to put an end to further investigations. Such a situation can result in medicalisation.



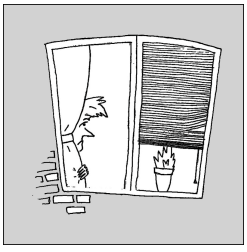
Peter *is a 37-year-old welder. He has had recurrent back pain that increases at work. Referrals to medical investigations, and different specialists, such as an orthopaedist and later a rheumatologist, have taken more than a year, and during that time he has been on sick leave. The investigations have not confirmed any diagnosis. He wants to know what is wrong with his back, and he feels that he cannot return to work.*

Harmed by sick listing—reversible The physicians perceived the main problem to be the iatrogenic adverse effects of long-term sick leave per se. Patients' self-confidence and motivation had diminished during, and possibly due to, the sickness absence, some being more vulnerable than others, but return to work was still possible.



Elisabeth *is a 52-year-old receptionist. Being healthy has always been very important to her. One year ago she had tachycardia while exercising, and the medical investigation showed that she had a congenital heart defect. Surgery was successful but a persistent infection in the operation wound prolonged the sick leave. She is now worried about returning to work, and she thinks that her job might be harmful to her long-term health.*

Harmed by sick listing—irreversible Here the physicians had feelings of frustration and sometimes resignation, because a patient focused on his/her inabilities and had adapted to the situation of not belonging to the work force. The prospects for change were perceived as minimal. This situation could be easier to accept if the patient was near old age retirement.

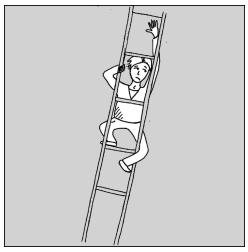


Tomas *is a 62-year-old truck driver. Three years ago, he injured his leg at work. Recovery was very slow and not complete, and he is still on full-time sick leave. He is on medication for hypertension and diabetes. His employer has no easier job to offer, and he himself is not willing to try anything but to go on disability pension.*

Sick-listing despite doubts Feelings of empathy and/or worry were more visible when the physicians experienced that their patients' recovery or reorientation took more time than expected. The physicians might have felt doubts about issuing sick notes if doing so was questioned by the employer or the Social Insurance Staff, but they still regarded sick-listing as the best alternative.

Sara *is a nurse aged 41 years. She had a severe depression when her daughter was born and has since then had a regular contact with a psychiatrist who has now retired. She has recently fallen in love with a new man, but, in the midst of this, she recognises the signs of depression. As part of her treatment, her GP has put her on sick leave for three weeks, but the SIO questions this.*

Risking harm by rehabilitation The physicians were concerned when they understood that a patient's resources and abilities were quite limited (e.g., involved an intellectual or emotional handicap) and that the rehabilitation procedures for return to work might be insulting or destructive.



Anna *is 57 years old. She has reading and writing impairments. Her work for many years in a kitchen at a nursery school has been much appreciated. All the cooking has now been reorganised and centralised to a large institutional kitchen, to which Anna has been moved. After some months, she still cannot manage even the least qualified tasks. She worries and has stomach problems and difficulty sleeping.*

6.2 STUDY II

Besides age and sex, the following information about the patients was often provided: family situation, stressful life events, occupation, problems at work, considerations concerning diagnoses, medical investigations, treatments, and vocational rehabilitation measures (Table 5).

Two thirds of the patients had been on sick leave for more than a year. The most common type of case reports concerned women who were employed in non-qualified nursing occupations and were on sick leave due to mental disorders. The measures most frequently implemented by the physicians were referrals to psychotherapy and/or physiotherapy, and prescribing of antidepressants.

Table 5 Categories of facts used to describe patients and categories of measures taken by physicians (given as numbers and percent of the 195 case reports), and findings for some of the categories

Category	Cases in which the category occurred		Findings for the category
	Number	*%*	
Sex	195	*100*	Women: 134; Men: 61
Age (years for both sexes)	195	*100*	Mean: 44.1; Median: 45
Marital status	140	*72*	Married: 94; Single: 46
Having underage children[1]	105	*54*	
Disease or resent death in close relative[1]	36	*18*	
Other stressful life event[1]	47	*24*	
Alcohol consumption	29	*15*	Yes: 12; No: 17
Occupation or profession	191	*98*	
Work-related problems[1]	73	*37*	
Sick-leave diagnosis	195	*100*	
Having a dog or horse[1]	6	*3*	
Country of birth (not Sweden)[1]	18	*9*	
Physical examination[1]	55	*28*	
Prescribe antidepressants[1]	62	*32*	
Work-oriented rehabilitation measures[1]	149	*76*	
Referrals	153	*78*	

[1]In none of the cases was information reported about *not* having any of the categories, such as not having children, dogs, or work-related problems.

6.3 STUDY III

In the case reports, there was a striving for neutrality, and the patients' stories tended to be interpreted within a traditional biomedical frame. In some of the reports, there was an open request for help, whereas in others it was not obvious that the physician was having any problems. Five "types of message" were identified in the 19 case reports written by physicians about problematic sickness certification.

A call for help These case reports were never in the form of mere medical charts but instead tended to be quite long and more complete stories. The manner of presentation was vivid and personal, and the physicians made efforts to make themselves understood. The word "I" was used in many of the reports, and the relationship with the patient was somehow always described. Different strategies to solve the cases and

feelings of helplessness were often presented, and there was sometimes a clear request for help.

A call for understanding This type of message was close to "a call for help" with an obvious emotional involvement of the physician, but expressions of frustration were visible to a larger extent than those of helplessness and asking for sympathy from colleagues. Multiple angles were seldom provided, and there were rarely requests for advice on alternative ways to handle a case.

Hidden worries These presentations were sometimes structured as medical charts with conventional headings like "background" and "status". The physician as a person was less visible, and so was the relationship with the patient. There was often a dramatic or even absurd touch, this effect being created by presenting contradicting episodes or facts. Expressions of feelings, opinions, and values were not explicit, and there were no obvious requests for help to solve the cases.

In my opinion Here the physician expressed involvement in the case in question, also thoughts about how she or he wanted it to be handled, but there were no clear requests for help from others. There were fewer expressions of being frustrated, and multiple angles were not provided.

Appearing neutral These presentations were either given as short medical reports or as actual copies of existing charts, and they comprised very few narrative elements. The physician as a person was more of a spectator, since her or his relationship with the patient was not presented. Values and opinions were seldom visible, and there was no request for help.

6.4 STUDY IV

In response to the general question about whether GPs find it problematic to handle sickness certification consultations, about half of the participants (54.5%) indicated that they had experienced this at least once a week (Table 6). Considering specific aspects, about one fourth (25.9%) of the GPs reported that at least once a week they had a patient who wanted a sickness certificate for some reason other than work incapacity due to disease or injury.

Table 6 Proportions of GPs (n = 2,516) who experienced various situations related to handling sickness certification

How often in your clinical work do you…	At least once a week % (95% CI)	About once a month or a few times per year % (95% CI)	Never or almost never % (95% CI)
... find sickness -certification cases to be problematic?	54.5 (52.6–56.5)	43.8 (41.9–45.8)	1.7 (1.1–2.2)
... encounter a patient who wants to be on sick leave for some reason other than work incapacity due to disease or injury?	25.9 (24.2–27.7)	67.5 (65.7–69.4)	6.5 (5.6–7.5)
... say no to a patient who asks for a sickness certificate?	13.9 (12.5–15.3)	82.3 (80.8–83.8)	3.8 (3.0–4.5)
… have a patient who, partly or completely, says no to a sick leave you suggest?	6.8 (5.8–7.8)	68.0 (66.2–69.9)	25.2 (23.4–26.9)
... issue a sickness certificate so that a patient will be eligible for higher than unemployment or social security benefits?	0.5 (0.2–0.8)	8.9 (7.8–10.0)	90.6 (89.5–91.8)
... have conflicts with patients about sickness certification?	11.3 (10.0–12.5)	74.6 (72.9–76.3)	14.1 (12.8–15.5)
... worry that a patient will report you to the medical disciplinary board in connection with sickness certification?	1.7 (1.2–2.2)	15.6 (14.2–17.1)	82.7 (81.2–84.2)
... feel threatened by a patient in connection with sickness certification?	1.4 (0.9–1.8)	21.3 (19.7–22.9)	77.3 (75.7–79.0)
... worry that patients will go to another physician if you don't sickness certify?	0.9 (0.5–1.3)	10.0 (8.8–11.2)	89.0 (87.8–90.3)
… have patients saying they will change physician if you don't sickness certify?	0.8 (0.4–1.1)	24.5 (22.8–26.2)	74.7 (73.0–76.4)

Regarding the severity of the reported problems, 58.1% indicated that they found handling sickness certification of patients as very or fairly problematic (Figure 3). Several of the issues that many of the GPs considered to be very problematic concerned assessments of functional or work capacity. Two other aspects that were rated as very or fairly problematic included handling situations in which the GP and the patient had different opinions about the need for sick leave (56.7%) and managing the two roles of being a physician for the patient and a medical expert for the SIO and other authorities (61.7%).

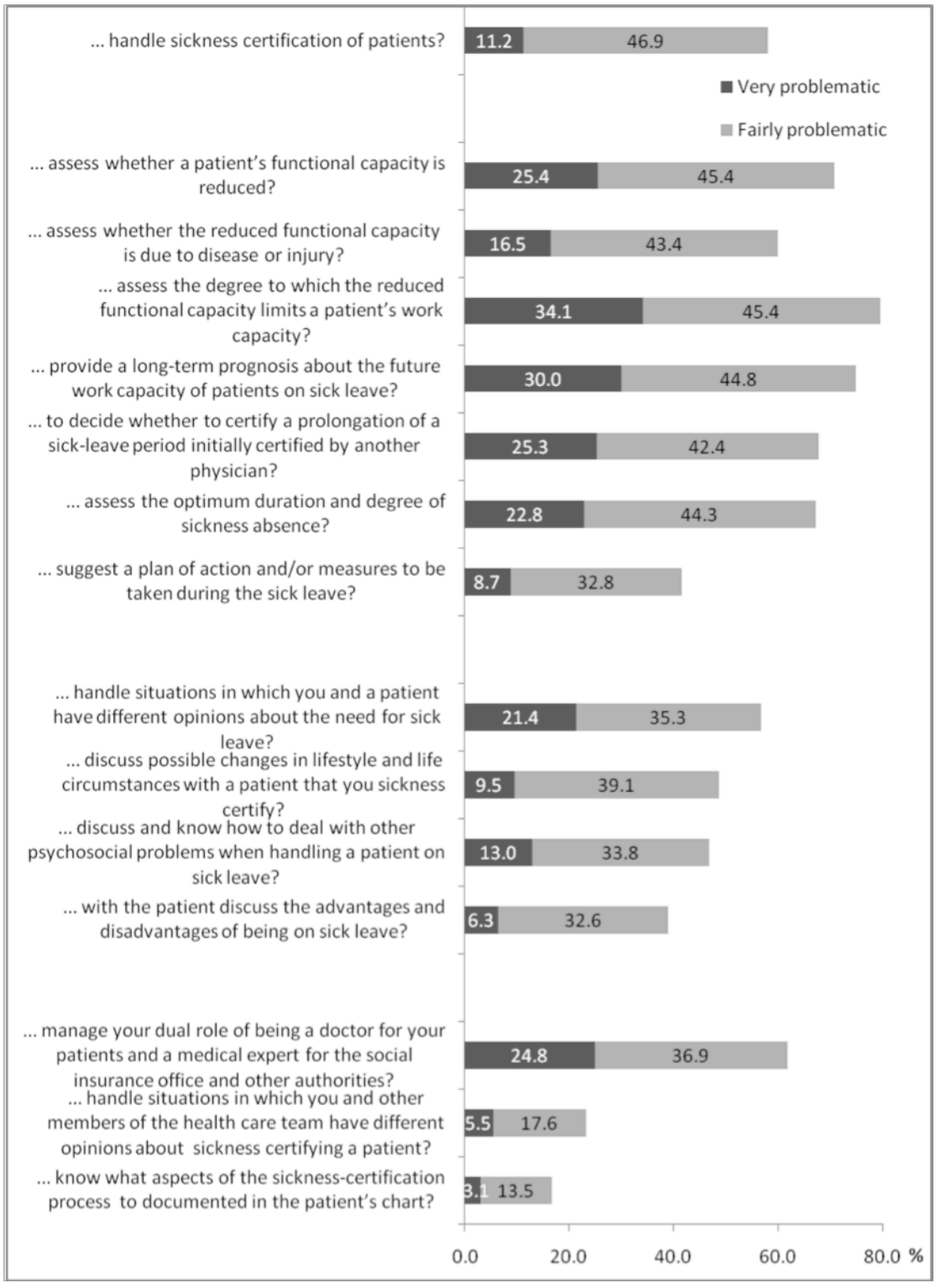


Figure 3 Proportions of GPs (n = 2,516) who rated different aspects of sickness certification as being very or fairly problematic.

A majority of the GPs stated that they certified unnecessarily long sick-leave periods at least once a month due to waiting times for investigations or medical treatments (not in table), but also because investigations at the SIO were pending. One third (31.3%) did this due to lack of access to cognitive behavioural therapy for a patient. Furthermore, some (22.4%) certified unnecessarily long sick-leave periods because the patient did

not follow recommendations about treatment and rehabilitation, and 12.0% did so to avoid conflict with the patient or because it took too long to explain the alternatives to being on sick leave (11.9%).

Regarding gender and age, there were some significant differences in responses to items about approving unnecessarily long sick-leave periods (Table 7). Male GPs issued certificates for such periods more often in order to avoid conflicts and because it took too long to explain the alternatives to being on sick leave. Regarding age, there were significant differences in responses to the items about following recommendations, avoiding conflicts, and being influenced by other members of the health care team. Other differences regarding age and gender were related to waiting times and lack of treatments (e.g., cognitive behavioural therapy).

Table 7 Proportions of GPs (n = 2,516) who, for different reasons and at least once a month, issued sick notes for unnecessarily long periods, shown by gender and age groups

How often do you certify unnecessarily long sick-leave periods due to…	Women (n = 1,135)	Men (n = 1,381)	32–54 years (n = 1,218)	55–64 years (n = 1,298)
... lack of next visit times?	26.7	26.0	27.8	24.9
... waiting times for investigation by health care services?	**63.9**	**66.8***	66.7	64.3
... waiting times for investigation by the social insurance office (SIO)?	51.0	52.4	52.4	51.1
... waiting times for investigation by the unemployment office?	31.6	30.0	30.0	31.5
... waiting for measures to be taken by an employer?	29.4	29.5	29.7	29.3
... waiting times for treatment?	**61.5**	**66.3***	63.5	64.7
... lack of access to cognitive behavioural therapy?	**34.0**	**29.1***	**34.1**	**28.5***
... lack of other adequate treatment and/or care provider?	**28.6**	**25.9***	28.0	26.2
... that the patient does not follow recommendations for treatment and rehabilitation?	23.0	21.9	**26.1**	**18.8***
... you want to avoid conflicts with the patient?	**9.2**	**14.2***	**13.5**	**10.4***
... it takes too long to explain alternatives to being on sick leave?	**8.8**	**14.5***	11.8	12.1
... influence of other members of your health care team?	7.3	7.3	**8.4**	**6.3***

*P < 0.05. **Significant differences indicated in bold type.**

7 DISCUSSION

This chapter begins by presenting considerations on the findings concerning the case reports as narratives and the implications of this aspect. Thereafter, a short summary of the physician tasks provides a background for understanding why and how physicians actually experience sickness certification as problematic. The frequency and severity of the problems are also discussed. Furthermore, some attention is given to possible explanations for varying rates of sickness absence and the physician's role in the sickness certification process. The next section discusses the materials and methods used in the four studies, and the last part is about implications for practice, further research, and medical education.

7.1 GENERAL CONSIDERATIONS ON THE RESULTS

7.1.1 The case report as a narrative

7.1.1.1 What is told?

There was a striking resemblance between the contents of the problematic sickness certification cases that the physicians wrote reports about. From our study, we conclude that the categories identified in study II (e.g., family situation, occupation, problems at work) could also be regarded as markers of problematic sickness certification cases in general practice and OHS. The idea of similar markers or risk factors has also been discussed by other Swedish researchers, such as Linton et al. (94) and Kaiser et al. (95).

The most common type of case reports in study II concerned female patients who were employed in non-qualified nursing occupations and were on sick leave predominately due to mental and/or musculoskeletal disorders. This agrees with official statistics showing that there is a higher rate of women that are sickness absent, and that mental and musculoskeletal diagnoses are the most frequent sick-leave diagnoses in Sweden (11) and other Western countries (10, 96). Lidwall et al. (97) found that, after the 1990s, long-term sickness absence was associated with being female and also with various aspects of the psychosocial work environment and job situations. In addition, the same research group (98) noted that extensive work responsibilities for men (i.e., higher socioeconomic status) and probably extensive family responsibilities for women were associated with increased long-term sickness absence. Several other studies have examined the connection between socioeconomic difficulties and sickness absence (99-101).

The material of case reports, about own problematic sickness certification cases, involved an even larger proportion of mental disorders compared to the long-term sick-leave diagnoses in the entire Swedish population (8, 102), which indicates that GPs and OHS physicians tend to experience patients with such conditions as more problematic than patients with other medical disorders. Furthermore, many of the patients in the case reports were described as having both mental and musculoskeletal disorders. A high rate of co-morbidity concurs with what was observed in another study of problematic long-term sick-leave cases (103). Also, physicians seldom tend to view the

more “obvious” diseases as problematic when they have to consider sickness certification (57, 70).

During the years when the material used in this thesis was collected, many sick-leave spells lasted for a very long time, in some cases for several years. Due to recent changes in the rules governing the course of rehabilitation, this is no longer possible (in Swedish *rehabiliteringskedjan*). In the material, long duration of sick leave was a prominent factor, so prominent that such absence in itself can be suspected of contributing to what makes physicians regard sickness certification cases as problematic. This was obviously often a consequence of the cases being perceived as problematic from the start, but the protraction per se becoming a problem as time passed. To our knowledge, no previous investigation has, clearly shown this association. Also, in a substantial proportion of the long-term cases, a physician other than the one doing the reporting had initiated the sickness certification. Having problems in managing such cases agrees with the findings of a questionnaire study conducted by Löfgren et al. (48)

Other categories identified in the analyses more closely reflected what the reporting physicians found problematic in their specific case. An example of this is that stressful life events were frequently described in the narratives. The physicians might have been trying to make their written case reports understandable and acceptable, both in the context of the course they were taking, and for themselves. The patients under consideration might have presented more symptoms, and/or they might have insisted on sickness certification. Still, from a narrative perspective, we also learned that it took a physician to make a case problematic.

7.1.1.2 What is not told?

Based on our pre-understanding of the research field, there were some categories that we expected to find quite often but that were instead rarely mentioned, and one of these concerned facts about alcohol habits. Inasmuch as the material consisted of a selection of problematic sickness certification cases, we had indeed anticipated that a certain amount of attention would be given to the possible role of alcohol, because several studies have shown an association between sick leave and alcohol consumption (8, 104-108). On the other hand, some researchers have found that many physicians find it difficult to discuss matters related to alcohol consumption with their patients (109, 110).

Another sparsely reported category was country of birth, which might have been considered likely to have shown up more often, since many of the cases were about psychosocial difficulties. However, there are no SIO statistics regarding possible correlations between ethnicity and sickness absence. Findings at physical examination were also rarely reported, even when the context of a case report was explicitly biomedical. This might indicate that such information was of minor importance for the physicians’ thoughts about their problematic cases.

7.1.1.3 How are things that are told actually related?

In the case reports analysed in study III, there was an obvious striving for neutrality in both content and form, which is also seen in other kinds of medical case reports, as

discussed by Greenhalgh et al. (111). The physician's personal and emotional involvement and the relationship with the patient were visible to varying extents in the written case reports. There were requests for help or for understanding in some cases, while in others the physicians' problems were less obvious. However, a striving for neutrality does not necessarily imply that the problem at hand is not acknowledged, although it does make that possibility less likely. If, even in practice, the physician responds to a problematic situation mainly by appearing neutral, there is a risk that ineffective and disease-oriented measures will be perpetuated, as shown in study II.

The current results can be compared with a textual analysis of essays written by medical students in the United Kingdom, in which Howe et al. (112) found linguistic clues to "depth of apparent reflection". According to those investigators, minimal use of first-person reflections might indicate students who need further professional development and support. Medical education per se tends to condition what can be termed the biomedical reflex (113, 114), which entails an immediate and disease-oriented framing of the presentation of symptoms that reduces the patient to his/her symptoms and physical signs by excluding the communicating student or physician from the professional perspective. Accordingly, medical students may lose some of their empathic competence along the course of their education, since encouraging empathy requires the recognition of a subject (i.e., the physician him/herself) who is open to the patient as a person (115). Hence the limitation to empathy should be reflected in the ways that qualified physicians produce texts in their professional role. Petter Aaslestad (116) has described how transforming the patient into an isolated medical text backwardly sets limits on the physician's relationship with the patient.

In a qualitative study by Malterud et al. (117), physicians were asked to write down a case in which their vulnerability towards patients had been exposed. A conclusion was that spontaneous exposure of emotions from the physician might lead to constructive interaction with the patient. In line with this, in study III, we found that the type of message referred to as "a call for help", which includes both emotions and a striving to realise different aspects involved, and to some degree the physician's relationship with the patient as well, is likely to provide new perspectives on the case and also give the physician writing the report responses from colleagues. On the other hand, "a call for understanding" (i.e., asking for sympathy from colleagues) exposes a reluctant attitude towards reframing a problematic situation that one actually recognises. In other words, it reveals ambivalence. Being unable to manage such reframing in daily work would increase the burden of less effective practice.

By comparison, the emotional involvement in the type of message that we designate "in my opinion" is more defensive. It is assumed that the problem is outside of the doctor-patient interaction, which might be both correct and incorrect. If the physician tends to take on heavy responsibility for the patient in financial terms and/or regarding more general acceptance of the role of advocate (64, 67, 118), professional distance may be lacking. On the other hand, the message "hidden worries", which in some cases includes elements of irony or even cynicism, may reflect a non-professional distancing to the problems faced. It is worth noting that cynicism might be a sign of exhaustion or even burnout among physicians and other medical professionals (119, 120). This

potential connection merits some attention, because it has been suggested that sickness certification is a work environment problem for physicians (48, 49).

In the role-play sessions and discussions at the courses, the physicians' problems often came into the open, and this was true even when cases were "appearing neutral" or had "hidden worries". An awareness of one's own feelings (e.g., frustration or powerlessness) helped the physicians to give names to the dilemmas they perceived. In agreement with this, Arborelius and Mathers (42, 44) have illustrated how feelings, especially those of uncertainty or "angry helplessness", can be useful information about a consultation.

7.1.2 The physicians' tasks in sickness certification

In Sweden, the SIO decides whether a person should be granted sickness benefits. However, in 2007, in only 1.8% of the cases was there a lack of concurrence between the SIO's decision and what the physicians recommended (121). This suggests that physicians have an informal and crucial task as gatekeepers, to certify that benefits are distributed rightfully. Another task is to make use of sickness certification as a type of treatment for the patient (22), implying effects that might be either beneficial or harmful. Our findings about what actually happens when physicians get stuck in sick certification consultations, illustrate the problems that arise in practice and are related to these two tasks.

For the patient, the sickness certification consultation is about both emotional support and confirmation, but also about financial issues. It is sometimes difficult for the physician, being educated in a biomedical tradition, to relate to the problems that are faced. Since the handling of sickness certification takes place on the borderline between medicine and society, certain tensions and problems will always occur. In accordance with our results in this thesis, Swartling et al. (122) performed an interview study and found large qualitative differences in GPs' views on sickness certification, which was experienced as being done on behalf of either society or patients, or as an integration of these two views. Some GPs expressed a feeling of strong conflicts between the interests of society and the patients, and others seemed to have solved the conflict and held a more integrated view. These findings are very close to what the categories of dilemmas (study I) in sickness certification are all about.

7.1.3 Physicians' practices in sickness certification

In a Norwegian questionnaire study performed by Gulbrandsen et al. (123), groups of GPs evolved based on their attitudes towards and how they experienced sickness certification (e.g., perceived burden, doubt, or permissiveness). There were marked differences in experiences between the groups, but no evidence was found of associations between group-level differences and sickness certification rates. According to the authors, this observation implies that it is the individual patient's situation (and possibly also the nature of the doctor-patient relationship) that decides what the GPs actually do when handling sickness certification.

According to the findings from study II, the most common measures taken by the physicians, besides issuing sick notes, were making referrals to psychotherapy and/or physiotherapy, and prescribing antidepressants. Those are actions that might be more relevant when patients are on sick leave due to psychiatric diagnoses such as severe depression or psychosis, which entail more clear-cut loss of function and incapacities. In this context, the actions taken seemed to reflect fruitless efforts to promote return to work.

Some of the reasons for certifying unnecessarily long sick leave (study IV) were related to the desire to avoid conflict with the patient, and more men than women stated this. Overall, there are contradictory findings, by other researchers (52, 70, 71), in differences according to gender and also to age of the GP in the use of sick leave certification. However, regarding consultation skills, there are findings indicating that female GPs practice more patient-centred consultations than their male colleagues do (124). Such skills might include the capability of handling conflicts and possibly also to that of taking time to discuss alternatives to being on sick leave with the patient.

7.1.4 Problems in sickness certification consultations

At the time of the collection of material for these studies, many physicians regarded sickness certification as a severe problem in their daily work (28, 47, 48, 93). In 2008, 21% of the GPs still stated that sickness certification to a great extent constituted a work environment problem (93). It is likely that some of the problems will diminish if sickness absence continues to decline, but probably tensions and dilemmas will always arise. The contribution of this research is to elucidate and give names to the specific difficulties experienced by physicians in consultations where sick leave is an option.

The findings from study IV showed that some of the problems reported are related to difficulties in making assessments of work capacity, while others are more closely associated with the patient-doctor communication per se, such as when it is necessary to handle both the expectations of the patients and conflicts that arise. On the same track, Timpka et al. (57) asked physicians to describe critical events and dilemmas in their practices in sickness certification. The first type of problems found concerned insurance-related questions, and the second type involved more clinical aspects, like establishing the diagnosis and determining the validity of the patient's story. The clinical categories of dilemmas that were found in this thesis (study I) point largely in the same direction. "Diagnosis as disguise" is common when there is a discrepancy between how the patient describes his/her problems and what the physician apprehends, and it is also probable that those types of cases are common when it is problematic for the physician to handle conflicts with the patient. If the physician still chooses to issue a sick note, "harmed by sick-listing" is an inevitable consequence.

The categories of dilemmas found (study I) are not dilemmas in themselves. The fact that a dilemma still often arises is because the boundaries of the physician's mandate are less distinct when meeting a patient face to face than when considering it in theory. As also described by both Englund and Rudebeck (46, 125, 126), problems arise when the physician has difficulties in determining that a patient might be entitled to sickness benefits according to the sickness insurance system and/or what is actually beneficial

for the patient (Figure 4). In some instances, the physician's decisions regarding to issue a sick note or not can be affected by more private thoughts or feelings, such as the fear of a patient becoming disappointed or angry when given a "no"(48, 50, 51, 127). In such cases, the physician is trapped between different considerations. We believe that this tension between "doing right" and "doing good" gives a picture of what can be especially problematic in sickness certification consultations, as compared to other problems that can occur in patient consultations.

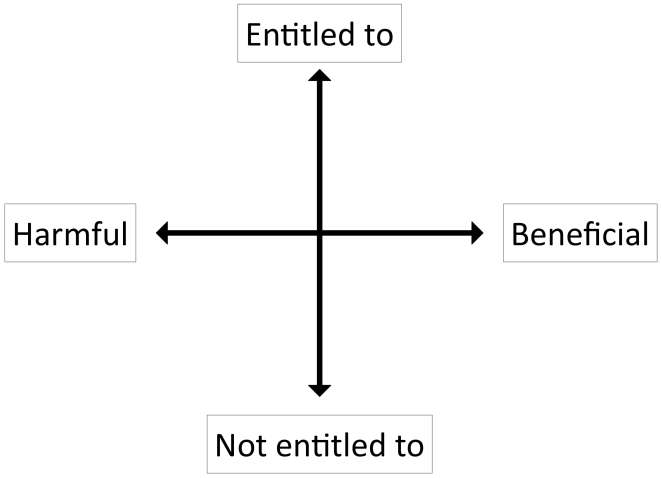


Figure 4 Diagram illustrating possible considerations regarding sickness certification (125).

7.1.5 Results in the perspective of varying sick-leave rates

The materials these four studies were based on were collected in the years from 2001 to 2008. The sick-leave rates had risen sharply before this period and then gradually declined after 2003 (Figure 1). According to two surveys in Sweden, 62 % of the GPs in the country had sickness certification consultations > 5 times a week in 2004, and the corresponding proportion in 2008 was 43 % (20, 28, 48, 93). This indicates that the frequencies of physicians' consultations, where sickness certification was an option, decreased considerably during the period of our studies. Such a major variation would indeed affect the physicians' work situation regarding sickness certification, both in terms of frequency and severity of problems.

There is no obvious explanation for this initial dramatic increase and the subsequent corresponding reduction in sick-leave rates, and such clarifications are not within the scope of my research. Still, there is a salient link between the sick-leave rates and this thesis. The extensive frustration felt by physicians in relation to sickness certification was one of the reasons for offering the courses that produced the material used in studies I–III. Approximately one thousand physicians participated in the courses, which gave them an opportunity to reconsider their own practice in problematic sickness certification and to try alternative actions. The experiences were also spread through many other educational activities, which were linked to local and regional initiatives throughout Sweden. The courses provided the context of the present research, and the

knowledge that they developed was very much influenced by the idea of a change in physicians' behaviour—from being defensive to becoming more reflective and conscientious. The results reported in this thesis represent facts and ideas that, in the hands of a physician, may offer a broadened repertoire of action.

This warrants some speculation about the role of physicians in the decrease in sick-leave rates that started in 2003 and subsequently continued. In a direct sense, the decrease was due to fewer and shorter sick-leave spells (11). This was probably partly related to fewer requirements and/or demands from the patients, which, in turn, might have been the result of a vigorous general debate about the high level of sickness absence and public information campaigns on that subject. Furthermore, it is likely that changes in public health (128, 129) and the labour market contributed to the situation (14, 97), and it is also possible that employers had become more aware of the importance of being active during the earlier phases of work impairment. However, researchers who indicated that reductions in rehabilitation offered a potential explanation for the dramatic rise in sickness absence during the 1990s (14, 130) were unable to demonstrate a corresponding increase in rehabilitation measures when the levels of absence decreased. On the contrary, in a recent randomised study carried out by the SIO, what were called "early interventions" had no apparent effects on length of sick-leave spells (131). Likewise, stricter interpretations of regulations and specific guidelines (5) could not be more than a partial explanation, since those measures were introduced after the drop in short-term sickness absence (11).

Regardless of several possible contributions to variations in rates of sick-leave spells, the individual physicians who meet patients in consultations where sickness certification is a possible outcome have an exclusive and independent role in deciding whether or not to issue sick notes.

7.2 METHODOLOGICAL CONSIDERATIONS

The nature of the research materials and the methods used in the present research are discussed in this section. Studies I–III are discussed together and study IV separately.

7.2.1 Studies I–III

7.2.1.1 Material

Regarding the participating physicians, who wrote the case reports, the vast majority of them were board-certified specialists in general practice, and many were also trained as physicians in OHS's and employed at such units, which might have made them more observant than other types of physicians about workplace factors. As teachers in the sickness insurance courses, we got the impression that factors such as the physicians' age, background, and motives for participating in the courses had no influence on how these medical professionals experienced difficulties in sickness certification.

Regarding the material, it consisted of almost 1,000 case reports and an equal number of discussions of the case reports (Figure 2). It is likely that most of the physicians who participated in the courses were motivated to reflect on their practice. They knew that their case reports would be read and discussed by smaller groups of colleagues. In this

context, writing down a problematic case might have had different functions for the physician. For some, predominantly those expressing “a call for understanding”, one such function might have been to provide a sense of belonging to a group of doctors who perceived sickness certification as problematic (28, 47). Others, such as those indicating “a call for help”, might also have hoped for concrete aid to handle their cases. In addition, those who expressed “in my opinion” or “appearing neutral”, or sometimes “hidden worries”, might have been more reluctant to expose their problems and shortcomings. If that was indeed so, we do not regard it as a confounder in the interpretation of our findings, but rather as an example of one of the factors in medicine that may have an impact on how physicians present their cases. Physicians who did not wish to take a sickness insurance improvement course may have fewer problems or be unaware of problems that they actually have, and it is not possible to judge the relevance of the results for those doctors.

The case reports were heterogeneous in both size and content. A limitation of study II was that some of the case reports provided nothing but the clearly defined categories (e.g., sex, age, and sick-leave diagnosis), and in a few of the reports it was not obvious that the physician had actually described a case in which he or she did not feel comfortable in the sickness certification role. However, there were a large number of case reports, which together proved to be rich in information.

Many of the results regarding sickness certification practice are time bound. However, the studies were conducted over a long period (Figure 2), and thus it is likely that most of the variations were captured.

7.2.1.2 Methods

7.2.1.2.1 Study I

The methodology in study I was ad hoc in character, because it was developed within the course context to reveal significant aspects of problematic sickness certification consultations. The research requirements came second to the educational prerequisites, which determined the course design. Role-playing and group discussions were chosen in order to get a sense of the meeting between physician and patient. The involvement and influence of the course participants was central, and the main task for the group leaders was to serve the educational objective, not to follow a protocol in the discussions. It was also declared that the course leaders had an ambition to support colleagues in managing the difficulties associated with sickness certification practice, which were described by many as constituting a work environment problem (28, 47, 48). The course participants were invited to identify new dilemmas, and there was no intention to restrict the number of categories. The separate group work done in each course continuously influenced the course process as a whole. This type of arrangement is similar to that in action research (132, 133), which is described as a reflective process of progressive problem solving. However, alternative ways of action were not tested in practice in study I.

The definition of a dilemma was not self-evident. A dilemma was considered to occur in typical situations, such as when a case was experienced as “not the doctor’s pigeon”. A more complete denomination would be “categories of situations that put the

physicians in a sickness certification dilemma" instead of "categories of sickness certification dilemmas". A common feature of all the typical situations was that the physicians had difficulties in acting in accordance with their sense of what was the right thing to do, and this was due to conflicting demands or loyalties.

There were some possible limitations of the methods used in study I. The categories were based on role-playing and group discussions of the case reports, and hence some useful information from the discussions might have been lost. Furthermore, the group leaders might have influenced the discussions so that some categories were dismissed, although consensus was not the main task. However, the description of situations that cause sickness certification dilemmas for physicians provides a fair picture of what is actually experienced in practice.

Still, the final exercise in each course, where the groups were asked to sort all the cases, clearly indicated that the categories had the potential to identify the difficulties experienced by physicians. This gave us a picture of the perceived clinical relevance, a concept influenced by Steinar Kvale's notion of "pragmatic validity" (134). Ideas or actions, "categories of sickness certification dilemmas", are considered true or relevant when they are of use in practice. The results of the final exercise were very much the same in each course, indicating that the categories were easy to recognise, although inevitably partly overlapping. Some of the categories were not common in the course context but were nevertheless clarifying when they did appear.

A later example of the pragmatic validity of the categories identified in study I is the obvious recognition by participants in about a hundred other courses (not those included in this thesis) and lectures where the categories have been presented. Indeed, it seems that medical students, physicians doing their internship or resident training, and board-certified GPs have all recognised the categories. Also, the results have been presented internationally (135, 136), and the response of recognition was striking, even among physicians working in countries with a system different from that in Sweden, or where the general sick-leave rates are considerably lower.

The foremost strength of this study was that we managed to put words to a clinical problem experienced by physicians. However, it is not possible to state what dilemmas are inevitable for any physician in any sickness insurance system. New categories might be added in the future, and, of course, other researchers might give them other names.

7.2.1.2.2 Study II

The strengths of this study were that a large number of case reports were studied that overall proved to be rich in information, and that as researchers performing the analyses we had different clinical and theoretical backgrounds.

The material of case reports was regarded as a large sample of narratives, "doctors' stories" (85), in sickness certification practice. Based on the understanding of the context for which the reports were written, it was possible to identify the main characteristics of the sickness certification cases that the participating physicians found problematic. The descriptive categorisation was inspired by the ideas that Ragin (90)

offered about how main causal conditions, shared by relevant cases, can be identified. Some of the categories recognised in the analysis, such as sick notes for prolonged periods, seemed to be more or less inevitable in most problematic certification case. Other categories reflected various numbers of aspects that the reporting physicians found problematic in their respective cases. Here, the selection was probably more conditional and depended more on individual characteristics of the physicians. Such characteristics were, however, not within the scope of this study.

7.2.1.2.3 Study III

When writing a case report, the physician processes his/her interpretation of the patient's problems to different degrees depending on the type of issue to be addressed and the patient's personality, and on the physician's own personality, competence, and ambition. Researchers who study narratives advocate that the main strength of such accounts is their inherent subjectivity (111, 137), and they mean that it is a challenge to capture aspects of this subjectivity as data in their context and to interpret that information appropriately. We had this in mind when categorising the types of messages in the reports with regard to both structure (81) and function (80, 83).

The reports that were analysed dealt exclusively with cases in which the participating physicians did not feel comfortable with their role in sickness certification. Reasonably, that created a larger span between the messages than would have been achieved if the sample had consisted of physicians' reports that were representative of sickness certification cases in general. In the case reports that were used in this study, "a call for help" was probably formulated more often and more expressively, while the attitudes of reluctance reflected as "in my opinion" and "appearing neutral" emerged in greater contrast. Still, we do not think that the selection of case reports in study III imposed attitudes on the participating physicians that were not, to any significant extent, originally theirs.

We cannot judge whether the findings in study III are transferable to problematic sickness certification consultations in real life. However, if there is any correspondence between writing about one's own practice and the actual practice itself, we believe that our findings provide some ideas that can aid the understanding of how feelings and thoughts contribute to the reflection-in-action in problematic sickness certification. Furthermore, the general character of the messages we detected suggests that they are also relevant for describing problematic situations other than sickness certification.

7.2.2 Study IV

The main strengths of study IV were the large number of participants (all the GPs in an entire country were included) and the many and detailed questions about different aspects of sickness certification tasks. This meant that many of the results from smaller studies could be tested in a population. A limitation was the high dropout rate: 40% of the physicians who had specialised in general practice did not complete the questionnaire (28), and we know very little about how they might have responded to the items. It is reasonable to assume that answers would have differed with age and

perhaps also with sex, which might have influenced to what extent problems were experienced, for example at different ages.

Another possible limitation, as seen in any questionnaire study, was that the participant's might have interpreted the questions differently. They might not have perceived concepts such as "problem" or "conflict" in the same ways, which means that the frequencies reported do not necessarily correspond with what was actually experienced or performed in practice.

It is also possible that some GPs encounter problems that were not included in the survey. However, the questions used in study IV were based on the results of previous questionnaire surveys in this area, as well as on individual and focus group interviews (20, 21, 47, 48, 62). Therefore, we believe that our findings represent good estimates of the type and severity of problems related to sickness certification in general practice.

7.3 IMPLICATIONS FOR PHYSICIANS' SICKNESS CERTIFICATION PRACTICE

Some of the reasons that the physicians themselves gave for writing sickness certificates for unnecessarily long periods of leave were associated with factual circumstances that the GPs had little chance of influencing, such as waiting times for other stakeholders. Other reasons were more closely related to the sickness certification consultation and concerned wanting to avoid conflicts with the patient. It is urgent that GPs develop strategies to manage complex certification consultations, and one way to do this was demonstrated in a British thesis written by Debbie Cohen (63, 64, 138). In the first step of her studies, a group of GPs met for several discussions, which were conducted according to the principles of motivational interviewing (139) and action research (132). Role-playing was also part of the concept. The members of the group helped to construct an e-learning programme aimed at improving physicians' ways of dealing with sickness certification and judging patients' fitness for work. The second step involved an intervention applied to a larger group of GPs, and the results showed that these GPs had achieved significantly improved confidence in managing a complex sickness certification case scenario, and they had become more prone to offer advice than to issue sick notes. This British experience agrees with the aim of the sickness insurance courses that were arranged for Swedish physicians.

We found that GPs considered assessments of functional or work capacity to be problematic, which concurs with the results of other studies (47, 48, 62, 65, 66). Education or training programmes might help solve such problems to some extent. In Norway, it was found that when structured functional assessments were introduced and implemented in general practice, GPs were able to evaluate the functional capacity of their patients in an organised manner and became more confident in these tasks (140).

The previously mentioned book by Hunter (85) described physicians' professional interaction with patients as an art that relies on interpreting the patient's story. If the physician is aware of his/her own feelings (42), it will make it easier to accomplish this interpretation and also to find alternatives to deal with the problems. Along the same

line, in the book entitled "The Reflective Practitioner: How Professionals Think in Action", Donald Schön (141) lays out the crucial role of "reflection-in-action" for the competence and professional behaviour of practitioners such as physicians. He advocates that practitioners should allow themselves to experience surprise or confusion in a situation that is uncertain or unique. By reflecting on the phenomena at hand, and on prior understandings, they can make new sense of situations of uncertainty, and alternative actions can be tried out in practice. Actually saying "no" to issuing a sick note might be one such action.

As also indicated in other studies (20, 52, 62), the problems in sickness certification involve areas such as the following: society and the social insurance system, the health care organisation, the performance of other actors in the system, and the working situation and practices of the physicians. My hope is that this thesis will contribute to high standards in sickness certification practices.

7.4 IMPLICATIONS FOR FURTHER RESEARCH AND MEDICAL EDUCATION AND TRAINING

Further research is needed to elucidate how physicians cope with the problems identified in sickness certification, because, if the complexity of the problems is not recognised, there is a risk that inadequate actions will be taken to solve them. It might be helpful to investigate if and how sickness absence rates are affected by courses and other interventions aimed at improving physicians' sickness certification practices.

A striving for neutrality, in both form and content, was a general inclination in the case reports about problematic sickness certification. It is possible that this aspect can also have a bearing on physicians' ways of expressing and relating to other clinical problems (42). The general character of the messages in the case reports supports this assumption. It would be highly interesting to further investigate physicians regarding possible associations between their reflection-in-action and the way they write about their corresponding cases.

Rita Charon (142, 143) and other researchers (144, 145) applying a narrative approach have presented findings indicating that using more reflective writing can strengthen medical students' empathic interaction with patients. When describing "the medical case" in writing, the process of making both the physician/student as a person and the relationship with the patient clearly visible may prove to be both a challenging and an enriching exercise. We also believe that by being more open and sharing the problems with colleagues, physicians can improve their ability to handle future problems perceived in all types of consultations.

8 CONCLUSIONS

The research results presented in this thesis contribute to the understanding of when and how GPs and OHS physicians actually experience sickness certification as problematic. The findings also provide knowledge about the frequency and severity of the problems that exist in that context.

Categories of dilemmas experienced by physicians in relation to sickness certification were identified, and common characteristics were pinpointed in case reports that GPs and OHS physicians had written to describe their problems in that context. It was found that the most common type of cases concerned women, many employed in non-qualified nursing occupations and on sick leave due to mental disorders. The most common, but seldom effective, measures taken by the physicians included giving referrals to a psychotherapist and/or a physiotherapist and prescriptions for antidepressants.

The meaning content of case reports about problematic sickness certification was explored. A common feature in the texts consisted of a striving for neutrality, and the physicians tended to interpret the patients' stories within a traditional biomedical framework. Still, the physicians displayed clearly different ways of relating to the problems they faced, and possible messages to colleagues who were intended to read the reports were identified.

In a national survey, GPs' problems in sickness certification were further elucidated regarding frequency and severity, which showed that these physicians considered assessments of work capacity to be very or fairly problematic. Other problems reported were related to the handling of situations in which the GP and the patient had different opinions about the need for sick leave, and managing the dual roles as physician for the patient and medical expert required to write certificates for the SIO. It was found that many physicians issued sickness certificates for longer periods than necessary for different reasons, often due to waiting times in health care and other organisations. Younger and male GPs more often reported that they did this to avoid conflicts with the patients.

The problems involved in sickness certification challenge physicians in different ways. Historically, handling of this duty has not been given high priority in what is otherwise a predominantly biomedical context. The results presented in this thesis contribute to understanding of how physicians actually experience this task, and thus they also enhance the possibility of dealing with the problems that are faced.

Some of the problems revealed by the research concerned assessing patients' work capacity and dealing with waiting times in health care and other agencies. Other problems were more directly related to meeting patients face to face. A common feature of typical situations was that the physicians had difficulties acting in accordance with what they felt was the right thing to do, and this was due to conflicting demands or loyalties. There were convincing similarities in the characteristics of sickness certification cases that were perceived as problematic, and some of those characteristics

(e.g., stressful events in the patients' lives) more closely reflected what the physicians found problematic in the specific cases. When physicians write down a case report ("tell a story"), they try to make the case understandable and acceptable both for themselves and for the colleagues who are intended to read the report. From a narrative perspective, it was obvious that it took a physician to make a case problematic.

Still further problems had a more general character and resembled those that occur in other types of consultations perceived as problematic. If physicians are aware of their own feelings (e.g., confusion or surprise), it might improve their ability to interpret problematic situations, and even provide alternatives for action in clinical practice. It is also likely that this will provide new perspectives on problematic cases for physicians who are expressing "a call for help" directed towards colleagues.

For the social security system in Sweden, it is essential that physicians, together with other stakeholders, do their share in dealing with the problems associated with sickness certification. To achieve this, they must face these problems as they actually appear in clinical work.

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