Physician Sickness Certification Practice

focusing on views and barriers among general practitioners and orthopaedic surgeons

MALIN SWARTLING
Dissertation presented at Uppsala University to be publicly examined in Robergsalen, Gamla Lungkliniken, Ing 40, Akademiska Sjukhuset, Uppsala, Tuesday, June 3, 2008 at 09:15 for the degree of Doctor of Philosophy (Faculty of Medicine). The examination will be conducted in Swedish.

Abstract

There is no common understanding on what constitutes good sick-listing, a frequent and problematic task for many physicians, especially general practitioners (GPs) and orthopaedic surgeons. Aiming to achieve a deeper understanding of sick-listing practices, 19 GPs (I, III) and 18 orthopaedic surgeons (II) in four counties were interviewed, and data analysed qualitatively for views on good sickness certification and barriers to desired practice. Data from a survey of all 7665 physicians in two counties on emotionally straining problems in sickness certification (IV) was analysed quantitatively.

Some GPs exposed narrow views of sick-listing, where their responsibility was limited to issuing a certificate, while GPs with the most inclusive view had a perspective of the patient’s total life-situation and aimed to help patients shoulder their own responsibility (I). The orthopaedic surgeons’ perceptions of good sick-listing were mainly related to their views on their role in the health-care system. Some perceived their responsibility as confined to the orthopaedic clinic only, while others had the ultimate goal of helping the patient to become well functioning in life with regained work capacity – by means of surgery and proper management of sick-listing (II).

Difficulty handling conflicting opinions was a barrier to good sickness certification for GPs (III), and problematic for about 50% of all physicians and about 80% of GPs (IV). Orthopaedic surgeons’ handling of such situations varied from being directed by the patient, via compromising, to being directed by professional judgement (II). Other barriers included poor stakeholder collaboration (III). GPs with a workplace-policy on sickness certification reported fewer conflicts and less worry of getting reported to the disciplinary board in relation to sick-listing (IV).

Understanding physicians’ underlying views on and barriers to practicing “good sick-listing” can inform efforts to change physician practice. Communications skills training in handling sick-listing situations with conflicting opinions is recommended.

Keywords: sick-listing, sickness certification, physician, general practitioner, orthopaedic surgeon, practice-pattern, barriers, phenomenography, Sweden

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List of Papers

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals.


II. Swartling, M., Wahlström, R. Isolated specialist or system integrated physician - different views on sickness certification among orthopaedic surgeons: an interview study. (submitted)


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## Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>GP</td>
<td>General Practitioner. A physician with specialist competence in general practice.</td>
</tr>
<tr>
<td>PHCC</td>
<td>Primary Health Care Centre.</td>
</tr>
<tr>
<td>PHCC physicians</td>
<td>Physicians working at Primary Health Care Centres. Most of these physicians have specialist competence in general practice <em>i.e.</em> are GPs, but not all of them.</td>
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</table>
Operational definitions

Disability pension A temporary or permanent disability pension granted to an insured individual with a permanent or prolonged reduction in work capacity due to disease or injury.

Sickness benefit A sickness allowance or cash benefit granted as stipulated by the Public Insurance Act [1] when a person’s capacity to work is reduced owing to illness/disease or injury. Corresponding terms in the literature are sick pay and sickness compensation.

Sickness certificate A certificate issued by a physician to ascertain that a person has reduced work capacity due to an illness/disease or injury. Sometimes called “sick-note”.

Sickness certification The process of filling in a sickness certificate as well as all aspects and behaviours in relation to this. Synonymous with “sick-listing”. Others have used sickness certification to denote filling the sickness certificate only [2].

Sick-listing The process of filling in a sickness certificate as well as all aspects and behaviours in relation to this. Synonymous with sickness certification.

Sick-listing commission The entrusted task of sick-listing – the mandate to sick-list (In Swedish: sjukkrivningsuppdrag).

Work capacity The functional capacity of an individual in relation to work demands at the place of employment, or to tasks performed in any job on the labour market if the individual is unemployed. Same as work ability.
I lived and worked as a General Practitioner in Uganda from 1998 to 2000. My Ugandan patients rarely had health insurance at all, and when they did it only covered the health care cost, not the loss of income. If my patients did not work they simply had no income, which often meant the whole family had no money for rent, food and school fees – quite different from the situation in Sweden.

When I returned from Uganda and resumed my work as a physician in the Swedish health care system, I was insured again from day one, and very pleased to be so. I also felt good about my patients having insurance coverage for their loss of income. This was in 2000 – at a time when sickness absence was on the rise, and “burnout” was a much debated diagnosis in the media. I felt that many of my colleagues were handling this welfare benefit very loosely, and that colleagues and other staff, took for granted that I would sick-list healthy relatives of my seriously ill patients, just as they did. To me this was fraud, although most of my colleagues found sick-listing healthy relatives to be perfectly normal, and for a while I doubted my own judgement. To me, if the relatives needed sick-listing they should have their own physician sick-listing them – someone having them in focus, considering what would be good and health-inducing for them, not only for their sick relative. I was very upset and was caught in a moral dilemma. Should I refuse to obey my superiors or should I act in opposition to my moral principles (and the regulations). This made me wonder how differently sick-listing could be perceived by different physicians. There were obviously other perceptions than mine, but what were they? This was the trigger for this research.

I am now specializing in rehabilitation medicine where, to me, the benefit of work as a health-inducing aspect of life for many patients is sometimes striking.

I am pleased to live in a country which has this social insurance benefit for the protection of people who lose their work capacity due to disease or injury, and I really want to preserve it. If overused, regulations will have to be changed, i.e. made less good, which will strike first at the leastfortunate individuals, who cannot afford or will be denied private insurance.

If my research can contribute even a tiny bit to Sweden maintaining good sickness insurance I will be pleased.
Background

In many countries, when a person’s capacity to work is reduced due to disease or injury, she or he has a statutory right to receive sickness benefits (cash benefits). After a short period of self-certification a physician’s certification of reduced work capacity due to disease or injury is needed, in order to continue receiving sickness benefits. This is called sickness certification or sick-listing.

General Practitioners, GPs, and orthopaedic surgeons are the two single groups of physicians whose jobs include most potential sickness certification cases [3]. They have been shown to differ in their sickness certification practices [3-5]. This is the reason I have focused on these physicians in this study.

There is no common understanding or knowledge among physicians, social insurance representatives or within the research community about what constitutes optimal sickness certification, i.e., sickness certification that maximizes the positive while minimizing the negative effects for the patient and society [6].

There are several risk factors for sickness absence. To be sick and to have a diagnosis is not sufficient in itself, and most people with a diagnosis are not on sick leave [6, 7]. Risk factors for disease and for sickness absence are not the same [6]. Studies on sickness absence have been carried out from different perspectives and within different scientific disciplines (table 1). The majority of studies on sick-leave have focused on the causes of sick leave [6], while few studies have addressed sickness certification practice [6, 8], which is the focus of this study. Sick leave is influenced by factors at different structural levels, but published studies have mainly addressed factors at the individual or workplace levels [6].

Historical background

In all societies there are individuals unable to support themselves owing to disease or injury. In peasant societies there was “sickness insurance” through the extended family, and this is still the case in many low-income-countries. When more people start to sell their labour, staying far away from the extended family, other solutions are needed. In the 18th-century sickness funds were set up in Sweden where one could apply to be a member [9]. The number and importance of such sick funds had increased substantially by the
Table 1. Categories used to classify studies in the Systematic review on Sickness absence by the Swedish council of Technology Assessment in Health Care (SBU) 2004 [6]

<table>
<thead>
<tr>
<th>Perspective taken in the study</th>
<th>Scientific discipline</th>
<th>Focus of the study</th>
<th>Structural level of the factors included in the study</th>
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<tr>
<td>National</td>
<td>Medicine</td>
<td>Risk factors for sick leave</td>
<td>Individual level (physical psychological, social)</td>
</tr>
<tr>
<td>Local</td>
<td>Sociology</td>
<td>Physician sickness certification practices</td>
<td>Family</td>
</tr>
<tr>
<td>Insurance office/company Health services</td>
<td>Psychology</td>
<td>Consequences of sick leave Methodological studies</td>
<td>Workplace</td>
</tr>
<tr>
<td>Employer Lay person/sicklisted/patient</td>
<td>Law History</td>
<td></td>
<td>National level</td>
</tr>
<tr>
<td></td>
<td>Philosophy Anthropology Sociology of law Organizational psychology (= management)</td>
<td></td>
<td>International level</td>
</tr>
</tbody>
</table>

Categories studied in this thesis in *italics*

End of the 19th-century, as the country became more industrialized. Physicians played a role by issuing certificates which gave the insurer a basis for accepting or rejecting applications for membership; people with medical problems were often denied membership, and the fees increased with age [9]. Public compulsory sickness insurance was instituted in Sweden in 1955.

Today adults of working age (16-65 years) in Sweden are covered by public sickness insurance. Even the unemployed and students are covered in most cases. This insurance is regulated in the Public Insurance Act from 1967 [2] (*Lag om Allmän Försäkring*) and is designed to protect the individual against loss of income in case of work incapacity due to sickness or injury [6]. Within certain limits, this insurance currently makes up the equivalent of 77.6% of a person’s lost salary.

After the first week of self-certification a person who is absent from work (or unable to actively seek employment) because of sickness or injury, has to be “sick-listed”, *i.e.*, to obtain a certificate issued by a physician as a basis for the employer (or in case of unemployment for the case manager at the local insurance office) to grant sick leave benefits. After two additional weeks, a case manager at the local insurance office (*Försäkringskassan*)
should formally decide whether an insured person is eligible for continued monetary remuneration.

Negative consequences

There are indications that sick leave and disability pensions may have negative effects for individuals, such as less promotions and salary raises [10], increased risk of suicide among men [11], and increased overall mortality [12]. A high rate of sickness absenteeism has also been shown to increase the risk of job termination and unemployment among women in temporary public sector jobs [13].

Sickness insurance is also costly. In December 2006 approximately 5 769 000 people (16-65 years of age) were insured in the Swedish health insurance system. Of these almost 555 000 were on disability pension and 194 500 were on sick leave since 15 days or more the last day of December. An additional 200 000 to 250 000 people are estimated to have been on short term sick-leave remunerated from the employer during the same month [14]. Thus, in all almost 1 million people of the workforce were off on some sort of sickness benefit on any one day.

The cost of sick-listing from day 15 was SEK 36.7 billion\(^1\) in 2006 and the prognosis for 2008 is SEK 34.4 billion. The cost of disability pension was SEK 74.9 billion\(^2\) in 2006 and the prognosis for 2008 is 72.9 billion [15]. The cost of the first 14 days of sick leave are not included in these estimates.

The number of people on remunerated sick leave in Sweden more than doubled between 1997 and 2003 [14, 16], without evidence of a corresponding increase in morbidity [17]. After peaking in April 2003 the number of sick days has since slowly declined, partly owing to an increase in the number of disability pensions granted during the same period [16]. The decline has since continued. However, fluctuations in the number of sick-leave days are nothing new (see Fig 1).

Physician sick-listing practices have been an issue of debate for the past 40 years, particularly during periods when sickness absence has increased [8]. Physician sick-listing practice is one determinant for the level of sick-leave [8].

\(^1\) Including the costs of retirement pensions
\(^2\) Including fees for retirement pension and for housing-allowances for people with disability pension
Physicians’ tasks in sickness certification

In most countries with sickness insurance the sickness certifying physician is supposed to [8]:

1. determine whether disease or injury is present
2. determine whether the disease or injury impairs the work ability in relation to either the patients current work (in case of short term sick-listing), or in relation to other job options available on the labour market (in case of long term sick-listing)
3. consider, together with the patient, advantages and disadvantages of sick leave, such as the risk of isolation, mental reactions, substance abuse, etc.
4. determine the degree (25% 50% 75% or 100%) and duration of sick leave and the medical investigation, treatments, or other interventions needed during the sick-leave period
5. issue a certificate that provides sufficient information for the case manager at the social insurance office to decide whether the patient has a right to receive sickness benefits and the possible need for other return-to-work measures

Swedish physicians have a wider responsibility in comparison with physicians in many other countries [6]. In Sweden the task also includes to:

6. determine whether there is need for contact with other specialists, the social insurance office, occupational health services, employer or other parties and in such cases establish collaboration with other parties within and outside of the health care system.
Gate-keeping and the double role

In sickness certification the physician is thus expected to serve as an expert in relation to the insurance authorities [8]. Physicians can thus be seen as informal gatekeepers in the Swedish sickness benefit system, since they mediate between the wishes of the patient and the formal rules [8, 18].

However, the formal gatekeepers in relation to sickness benefits, according to the law are the employer and the social insurance office [19]. The necessity of gatekeeping is usually underscored with three types of arguments: the need to ensure that patients receive appropriate care, the need for budget control, and the need for fairness in the distribution of benefits [20]. Not only do physicians have an expert role in relation to the authorities, they are also supposed to be the patient’s doctor with the patient’s best interest in mind. This “double role” has been reported to be problematic for physicians [8, 21-23] and more so for GPs than for other physicians [3]. One explanation for this could be that, compared to hospital physicians, GPs more often perceive themselves as treating the whole person, rather than a sick or injured body part [24]. However, it should be noted that not only GPs, but also other kinds of physicians find this double role problematic [3] e.g. gynaecologists [25] and orthopaedic surgeons [5].

Frequency of sick-listing

It is presently difficult to estimate how frequent the sick-listing task is in the daily work of physicians in Sweden and other European countries, since different ways of measurement have been used [6, 26]. In an English study, GPs were shown to spend 13% of their time on sick-listing [27], while nine and eleven percent, respectively, of all consultations included sick-listing among Swedish [28] and German GPs [29]. However, in a Swiss study of GPs, sickness certificates were issued in only 4% of consultations [30]. About 40% of sickness certificates in Sweden are issued by General Practitioners (GPs) [31]. In a recent Swedish study, 60% of GPs and 80% of orthopaedic surgeons reported consultations including sickness certification six or more times per week [3], and 97% of GPs and orthopaedic surgeons had such consultations every week [5].

Practice variation

Sick-listing practices seem to vary between individual physicians [4, 32] and between physicians of different specialities [4, 31]. In a case-vignette study of GPs, orthopaedic surgeons and psychiatrists, the GPs were found to sick-list for shorter periods than psychiatrists, but for longer than orthopaedic surgeons for the same cases [4]. In a population based study it was found that sickness certificates issued by GPs on average were for a shorter period...
of time than those issued by other physicians [31]. Sick-listing practices also seem to vary between physicians of different sex [4, 28, 33]; female physicians sick-listed more than male physicians, irrespective of speciality and patient attitude [4] and female GPs sick-listed a larger proportion of their patients than male GPs [28]. Sick-listing practice may also vary depending on the length of the physician’s work experience; GPs with long experience in family medicine were found to issue more sickness certificates compared to those with less experience [34]. The reason for this variation is unknown [8]. However, the patient’s desire or demand for sick-listing may influence a physician’s decision to sick-list [28, 35], even in cases where signs [35], and the physician’s own judgement [28] speak against sick-listing.

There are many factors that can influence physicians' practice patterns other than physician characteristics. An overview by the Swedish Council on Technology Assessment in Health Care listed the headings: Patient characteristics, Physician characteristics, Interaction between physician and patient, Organisation of health and medical services, Workplace, Social insurance office, Other authorities, Society at large and Interactions between all these parties [8].

This study attempts to contribute to understanding how physician characteristics may influence practice patterns with focus on underlying views and barriers for good sickness certification.

Different views – different behaviour

How people perceive, conceptualise, understand or view the world and phenomena in the world influences their behaviour [36-39]. People with a more inclusive or comprehensive perception of their work behave differently, more competently, in comparison with those with a less inclusive view of the same work [36-38, 40]. Previous research has shown that individual physicians can adopt more inclusive views after an educational intervention [41, 42].

Barriers

It has been shown that by identifying and targeting barriers to change in practice, the chances of making interventions successful will rise [43, 44], but this seems to be forgotten in many situations [45]. Based on a review of 76 studies on barriers to guideline-adherence, researcher identified seven salient factors: lack of awareness, lack of familiarity, lack of agreement, lack of self-efficacy, low expectancy of favourable outcomes, inertia/lack of motivation and perceived external factors [46]. Lack of awareness and motivation, as well as perceived external factors, were particularly important barriers to adopting guidelines [46].
Stressful work

Physicians’ psychosocial work environment is generally characterized by a wide range of potential stressors, of which a number are intrinsic to medical practice itself, such as working with emotionally intense issues [47, 48]. Potential loyalty conflicts seem to be embedded in the role of the physician; on the one hand the physician is supposed to represent society and on the other hand to be the patients advocate [49]. This can give rise to a difficult “balancing act” [50]. Studies have documented lower quality of life [51], higher stress levels, and higher than expected rates of mental distress and psychiatric morbidity among physicians [52-59]. A fairly recent international systematic literature review established that physicians find handling sick-listing problematic [8], sometimes to the extent of being emotionally straining [3, 8, 21-23, 60-62]. Moreover, it seems GPs and orthopaedic surgeons experience sick-listing problems to a higher extent than other physicians [3], and that their coping strategies differ [5]. Sickness certification has been said to contribute to negative psychosocial working conditions [23, 63] and even been called a work environment problem [63]. However, the frequency of emotionally straining problems in relation to sickness certification is not known.

Need for interventions?

There seems to be large variations in sickness absence in different parts of Sweden and between male and female patients [14] There also seems to be large variations between different sick-listing physicians [4, 28, 31, 33-35]. The large increase in sickness absence in 1997-2003, without a corresponding increase in morbidity [17] and the fact that many physicians find sickness certification problematic [3], together with the extremely high cost, makes many policy makers, politicians and others feel that sickness certification needs to be changed in order to be more just for individuals, less problematic to physicians and more affordable to taxpayers, as well as safer to patients. The Swedish authorities therefore want to reduce the number of people receiving sickness benefits, as well as the extent and degree of their sick leave. The 2003 Government Proposition on changes in the social sickness insurance initiated a number of measures aiming to “increase health in working life” [64]. Restating that sickness certification should not be done on grounds of the labour-market, financial, or social grounds the proposition required sickness certificates to contain more detail, and several activities were instigated. These included among other things educating all physicians on insurance medicine [64]. Subsequently the Government has added more initiatives every year, notably the request [65] to develop National Guidelines for Sickness certification [66] and proposing set time-lines for review of eligibility and maximum length of sickness certification [67].
Prospects for changing physician behaviour

In contrast to the cost of health care and prescription drugs, the cost of sickness absence does not affect the health care system directly since sickness benefits are paid out of the national government budget, and not via the county councils’ budgets [68]. There are thus no direct financial incentives for physicians or the county council employing them, to keep the number of sick days down. Meanwhile, in primary health care, certification for sick leave may be the single most costly task to society of all medical actions [69]. In Finland, the mean cost of sickness absence constituted 42% of the total cost in relation to a medical appointment with a GP for neck or backache [70]. The cost of sick-listing may differ considerably between different physicians due to variation in sick-listing practice [4, 32].

A consistent finding in articles on quality improvement in health care is that change is difficult to achieve [71]. Traditional continuing medical education in the form of lectures has been shown to be unlikely to change professional practice [72-74], so has the use of printed educational materials [73]. Other approaches such as Audit and feedback, Interactive workshops, Educational outreach visits and local opinion leaders have all been shown in reviews to have varying degrees of impact, from small to moderate, on improving physician practice patterns [74-78]. Most studies have dealt with implementing evidence based practice [78]. A combination of methods has been shown to be more effective in achieving change [72]. Interactive communication skills training has also been shown to improve physicians’ practice [79].

Conceptual framework

Sickness certification practice can potentially be influenced by many factors [6] both relating to the patient (top half of Figure 2) and to the physician, (lower half of Figure 2). The patient and the disease or injury will affect the patient’s work capacity, which is central in the patient’s part of the sphere. The patient is also affected by factors such as sex, age, family situation and education. The work capacity in relation to the particular patient’s job, is influenced by factors at the patients’ workplace. It is also influenced by the patient's sex, age, and education, etc, and by the disease and its presentation and severity. The physician's part of the sphere can be “read” in the same way. Several factors influence the physician, such as age, sex, views, barriers and workplace.

Apart from the patient and the physician, the social insurance office, the Employment Agency and the Social Welfare Office also influence the sick-listing practice of the physician. (lower, left of Figure 2). Outside of the
sphere, laws and regulations, mass media and “zeitgeist” (secular trends) influence several of the factors within the sphere.

This study focuses on the physicians (mainly GPs and orthopaedic surgeons) and their views, perceived barriers and problems in relation to sickness certification. However, their views relate to a large extent to the patient, and the problems and barriers to good sickness certification relate to most other areas in the sphere, emphasising that reality is much more complex than this figure.

Figure 2. Potential determinants for physicians’ sick-listing practice

1EA = Employment Agency
2SWO = Social Welfare Office

Figure adapted from Diwan/Tomson IHCAR 1988
Justification

Physicians are key actors in issuing certificates for costly sickness absence [6], and authorities have tried to influence physicians’ sick-listing practice through initiating courses in sickness certification for all Swedish physicians [64].

There is knowledge that sickness certification is a fairly common remit for physicians [3] and that they find it problematic [3, 23]. It is also known that their sick-listing practices vary. However, the cause of this variation or the reasons why physicians act the way they do in relation to sickness certification is not known [8]. In order to understand why people, e.g. physicians handle situations and problems in a certain way, we need to understand how they perceive the situation or the problem they are handling or acting in relation to [80]. The ways people deal with situations spring from the ways in which they perceive, and make sense of the situations. People cannot act but in relation to perceived, seen and interpreted situations [80].

To understand why physicians handle sick-listing the way they do, we therefore need to understand how they perceive their sick-listing commission and good sick-listing practice, and how this might differ between individual physicians and between physicians of different specialities, e.g. GPs and orthopaedic surgeons.

We do not know whether physicians sick-list the way they think it should be done, and if they do not, the reason why. Are there barriers that need to be addressed in order to make it possible for physicians to change their sick-listing behaviour? If physicians do sick-list the way they think is best, while the level of sickness absence raises political concerns about costs and marginalisation of certain groups, interventions needs to address physicians’ views of what is good sick-listing practice. Increased understanding of physicians’ underlying views on sick-listing and barriers to what they perceive to be good sick-listing practice, can help inform effective interventions.
The overall aim for this study was to achieve a deeper understanding of sick-listing practices from the perspective of the physicians (mainly GPs and orthopaedic surgeons), as a contribution to the development of educational and other interventions.

The specific objectives were:

- To identify and describe the different existing views among Swedish GPs on sick-listing practices and on the sick-listing commission (Paper I).
- To identify and describe the different existing views among Swedish orthopaedic surgeons on sick-listing practice and on the sick-listing commission, and to compare this to GPs’ views (Paper II).
- To identify barriers preventing GPs from sick-listing the way they think is best (Paper III).
- To determine the occurrence of emotionally straining problems in handling sick-listing cases among physicians working at PHCCs, orthopaedic clinics, and in other workplaces (Paper IV).
Methods and study population

The main qualitative method used in this thesis is phenomenography. This is a fairly new and therefore not commonly known method of enquiry in health services research. Since an understanding of the concepts and underlying assumptions in phenomenography is fundamental to this study, I will start this section on methods by giving an overview of this approach.

Phenomenography

In seeking a better understanding of how GPs and orthopaedic surgeons view sickness certification we have used a phenomenographic approach (study I and II).

*View correlates to performance*

The way in which professional practice is understood is fundamental to how the practice in question is performed and developed both by individuals and collectively [39]. Individuals with different views or perceptions of the world have been shown to display different behaviours. Professionals with a more inclusive perception of their work behave differently and more competently than those with a less inclusive view of the same work [36-38, 40].

The phenomenographic approach was developed in the 1970s in research on learning [81, 82], but has later been advocated for and used also in healthcare research [83], where patients’ [84], physicians’ [35, 56, 85-88] and medical students’ [40, 89, 90] ways of experiencing or perceiving central phenomena have been explored.

The phenomenographic research approach aims at identifying and describing qualitatively different ways of understanding or experiencing phenomena in the world [91]. A phenomenon can in theory be perceived in an infinite number of ways. However, in the process of constituting meaning only a limited number of ways of understanding will result. In phenomenographic studies it has repeatedly been found that “each phenomenon, concept or principle can be understood in a limited number of qualitatively different ways, usually between two and six”, provided that the group investigated is relatively homogenous [91]. The main outcome of a phenomenographic study is a set of different “categories of description” of conceptions, or views
The structure of the categories of description can also be examined to find the “outcome space” [92], which shows how the categories of views relate to each other, often in a hierarchical way. Perception, conception, view and understanding are used interchangeably in this thesis.

It should be noted that a perception or view is not the same as an attitude, opinion or value. A perception of a certain kind is nothing one chooses to have – one cannot choose how to view or understand the world, or a phenomenon in the world. Phenomenography studies the perceived world – not the world “as such” [81].

First and second order perspective

Data in phenomenographic studies usually consist of transcribed interviews. The informants are asked to talk about the phenomenon under study in a way that reflects their own experience of the phenomenon. The questions are posed in such a way that a “second order perspective” rather than a “first order perspective” is taken [83]. From the first order perspective the aim is to describe various aspects of the world, while from the second order perspective the aim is to describe people’s experience of various aspects of the world [81]. A first order perspective of a phenomenon answers the question; What is X? A second order perspective of a phenomenon answers the question: How do people within this or that group perceive the phenomenon X?

The research process

Analysis in phenomenographic studies can be done in different ways [92]. For example, some researchers stress the importance of using the whole interview transcript all through the analysis [93], while others take smaller parts of text that are separated from the transcript and combined for analysis in one decontextualized “pool of meanings”, although these segments are still interpreted within the larger interview context [91].

In some phenomenographic studies, the perceptions of the phenomenon under investigation are presented as views of different domains of the phenomenon [85, 86], while in other cases the ways of understanding a phenomenon are presented under that phenomenon as an entity – the presentation is not split into the different domains of the phenomenon under study, as for example in a study on GPs’ views of asthma [56, 89]. This choice appears to depend on the scope of the phenomenon under study.

In some phenomenographic studies, as in our studies, individual informants are correlated to single categories [40, 56, 86-88]. In other studies conceptions or views are not assigned to an individual, but rather seen as a feature of the outcome space of the whole group [37, 94].
Overview of methods

Table 2. Study samples and methods for data analysis

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<tr>
<td>I</td>
<td>Interviews with 19 GPs in four counties in mid-Sweden performed Nov 2003-June 2004. Same material as for study III</td>
<td>Phenomenography</td>
</tr>
<tr>
<td>II</td>
<td>Interviews with 18 orthopaedic surgeons in mid-Sweden performed May-July 2004</td>
<td>Phenomenography</td>
</tr>
<tr>
<td>III</td>
<td>Interviews with 19 GPs in four counties in mid-Sweden performed Nov 2003-June 2004 Same material as for study I</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td>IV</td>
<td>Answers to six question, on emotionally straining issues, in a questionnaire sent to 7,665 Swedish physicians in two Swedish counties in October 2004</td>
<td>Statistical methods: Chi 2, bivariate and multiple logistic regressions (on dichotomised outcomes), Kendall’s tau-b, Odds Ratios</td>
</tr>
</tbody>
</table>

Study I, GPs’ views on sick-listing

Interviews with 19 GPs in 17 Primary Health Care Centres (PHCCs) in four counties in mid-Sweden were performed at a place of the GP’s choice, using a semi-structured interview guide (Annex 1). Physicians were purposively sampled across sex and age (born before 1950, 1950-1959 or 1960 and later), and the location of the PHCC. Focus was on the GP’s own experience of handling cases of sick-listing, seeking descriptions of concrete situations. Interviews were tape recorded with verbal consent and transcribed verbatim. Interview transcripts were analysed with a phenomenographic approach aiming to uncover existing views regarding the respondents’ sick-listing commission and practice. After perusal of all transcripts, the most significant statements made by each informant regarding a certain domain were selected to give a short but representative version of the entire dialogue on that topic. The domains were not preconceived apart from that of “the sick-listing commission” [sjukskrivningsuppdraget], but emerged from the interviews [95]. The condensed expressions under each domain were then compared independently, by two members of the research team, to find similarities and
differences that could justify grouping into different “categories of description”. The different groupings were then compared [95], and in study I, but not for study II, also discussed with a third member of the team. This procedure was then repeated for each domain of our interest. For each domain, each individual GP was only assigned to one category. NVivo qualitative software was used to manage the material [96].

Study II, Orthopaedic surgeons’ views

Interviews were performed with 18 (16 men) specialists in orthopaedic surgery working at five different orthopaedic clinics in four counties in mid-Sweden, using a semi-structured interview guide (see Annex 1). In the targeted clinics there were 108 specialists (98 males) and two of the clinics were at university hospitals and three were county referral hospitals. Focus was on the physicians’ own experience of handling cases of sick-listing, seeking descriptions of concrete situations. Interviews were tape recorded with verbal consent and transcribed verbatim. One (male) interview had to be excluded due to extremely poor sound quality. Analysis was performed as for study I.

Study III, Barriers

The study population was the same as for study I. When we began analysing our interview data for barriers for good sickness certification, we found that although it had been gathered with a phenomenographic analysis in mind, phenomenographic data analysis did not suit the question on barriers to good sickness certification, since the utterances about barriers were of a more ‘factual’ nature and did not generally demonstrate ways of thinking that could be described as views or conceptions. Qualitative content analysis [97] was therefore chosen.

All transcripts were read several times by the first and last authors to get a general overview. From the interviews all passages concerning barriers for what the GPs perceived to be good sickness certifications were selected and marked by the first author. Text regarding difficulties in relation to sickness certification was also marked in order not to miss any passages having to do with barriers without the informants’ awareness. A list of all marked passages constitutes the unit of analyses. The list was read by the second author, cross-checked by the last and found to correspond to the full transcripts and to be the relevant excerpts about such barriers.

The text was divided into meaning units that were condensed. The condensed meaning units were abstracted and labelled with a code (e.g. “time”,

25
“employer”, “Social Insurance Office”, “fear of conflict” etc). The whole context was considered when condensing and labelling the meaning units with codes. The codes were sorted into categories and subcategories by the first and the last author and crosschecked by the second author. Agreement on categorisation was strong. Disagreements were discussed until consensus was reached. The categories were initially more than twenty, but were collapsed through discussion.

Study IV, Emotionally straining problems

As part of a larger study all 7,665 physicians below the age of 65 in two counties in southern Sweden were approached [3], by means of a cross sectional postal questionnaire. The response rate for the 83-item questionnaire was 71%, and non responders did not differ between the two counties or in relation to their sex. The internal non-response rate was low. Seventy-four percent (4,019) of the participating physicians stated that they had consultations including consideration of sickness certification at least a few times per year, and 3,997 of them stated what type of clinic they worked in. These 3,997 physicians constitute the study population.

Answers to six questions related directly or indirectly to what physicians have been shown to find emotionally straining [22, 23, 60] were chosen as outcome variables (Annex 2). Kendall’s tau-b was used as a measure of association between the six outcomes [98].

Workplace i.e. PHCC, orthopaedic clinic, or elsewhere, were chosen as independent variables. Covariates studied included specialist status, sex, age, years of work, reporting support from management regarding sickness certification, reporting having a workplace policy for handling of sickness certification, and six or more consultations per week including consideration of sickness certification.

Comparisons between groups (PHCC vs others and orthopaedic clinics vs others) were done using the chi² test [99]. Bivariate, and multiple logistic regressions were performed, using dichotomised answers to the six questions in the questionnaire (Annex 2) regarding different perceived problems to investigate associations between variables. Crude and adjusted odds ratios (OR) were calculated with 95% confidence intervals (CI). All analyses were performed using SPSS 13.0.
Results

Study I, GPs’ views on sick-listing

There were qualitatively distinct differences in GPs’ views on sick-listing. Report on their views within three domains is given: 1) the sick-listing commission, 2) sick-listing practice and 3) responsibility for sick-listing and rehabilitation

1. Sick-listing commission

GPs viewed their sick-listing commission as coming either from society, or from patients (including no responsibility for societal interests, and in some cases no responsibility for rehabilitation either). Some GPs had combined these two views to an integrated commission. All GPs were aware of a possible conflict between the interests of society and patients, which has been called the double role. Some expressed feelings of strong conflict, while others – all women – seemed to have solved the conflict between these two loyalties, although by different means.

Only one physician talked explicitly about feeling threatened in relation to sickness certification.

2. Sick-listing practice

Four different ways of understanding sick-listing practice were identified:
2 a) Issuing a certificate: Sick-listing is understood to be the issuing of a certificate. Sick-listing is commented on without reference to good or bad practice, and without reflection on one’s own actions. Alternative ways of sick-listing are not recognised. Sick-listing is used while waiting for somatic investigations, for patients to heal by themselves, or when patients say they cannot work.

Yeah, I haven’t thought much about any other ways of sick-listing than the way I do it now. I don’t know how I would perform it differently. (Dr N)

2 b) Changing work situation: Beyond issuing a certificate, good sick-listing is understood as helping the patients to change their work situation. Changing the private life situation is not considered in the scope of possible objectives.
It must be possible to adapt jobs to the individual, rather than vice versa. (Dr B)

2 c) Changing lifestyle: Beyond issuing a certificate, good sick-listing is understood as helping the patients to change their lifestyles to better cope with the demands of work. Changing the work situation is not considered.

She is recommended physiotherapy regularly, and exercise at the physiotherapist’s [...] Try to eat better, live better, simply to have the [physical] qualifications to do this job. (Dr M)

2 d) Holistic view: Good sick-listing is to recognise the illness or injury preventing the patient from work, in a perspective of both the working and the private life situation. Good sick-listing practice includes addressing all identified problems, in order to rehabilitate the patient’s working capacity. This more inclusive view embraces the two views 2b and 2c.

But the right thing is that you get support and help to change yourself so that you can handle your own work situation and your family situation. (Dr E)

3. Responsibility for sick-listing and rehabilitation

Five different views were found regarding who bears what responsibility in relation to sick-listing and rehabilitation back to work: The Passive, the Protecting, the Authoritarian, the Supporting and the Empowering. A full description is only given here for the least inclusive, the Passive and the most inclusive, the Empowering.

3 a) The Passive: Physicians have no responsibility for the patients’ rehabilitation back to work, nor do they have any responsibility to make sure the patients themselves shoulder such responsibility. The physician allows the patient’s ideas of what is possible determine the sick-listing, seemingly disregarding their own judgment of suitable measures. GPs holding this view experience strong conflict between commissions and express feelings of distress. They seem to have very few tools to handle sick-listing situations.

I always ask if they could consider working at all. I always assume they can, but it’s not often they are of the opinion they can do that. One should perhaps contact employers more, because many patients say ‘It is not possible, because the employer won’t accept it.’ And that I don’t know. I don’t call the employer to check. (Dr C)

3 e) The Empowering: The physicians’ responsibility is helping the patients to shoulder their responsibility for their own sick-listing, rehabilitation and whole life situation. If disagreement between the physician and the patient occurs on the need for sickness certification the physicians compromise or follow their own judgment, making their own decisions.
I write it down, because they don’t remember […] otherwise: Find out the name and telephone number to 1) your case manager at the social security office 2) your immediate boss and 3) the occupational health service. […] And simply by doing something, a process starts in people. Nearly all of them actually do it. (Dr K)

Because most people immediately say something like: ‘No, that’s not possible at my workplace.’ and ‘It will never work.’ […] I say: ‘That’s what all employers say, but it’s not like that and I’m not allowed to take that into consideration. (Dr A)

Combinations of views
In the last stage we explored how the presented views within different domains were combined for individual GPs (table 3). Moving from the least inclusive Passive view (3a) to the most inclusive Empowering view (3e) on the responsibility for sick-listing and rehabilitation, the GPs successively hold more and more inclusive views also of the other aspects of sick-listing, see table 3.

The GPs with the Passive view on responsibility (3a) have the same combination of the least inclusive views on the other domains: they view the sick-listing commission to be a ‘Patient’s commission’ (1a) and understand sick-listing as limited to issuing a sickness certificate. They see no alternative ways of sick-listing (2a) and experience strong conflicts between the patient’s and society’s interests and feel distressed in the sick-listing situation.

At the other extreme we find the GPs with an Empowering view of the responsibility for sick-listing and rehabilitation, where GPs hold the most inclusive view of all three domains within sick-listing (1d, 2d, 3e).

GPs expressing a combination of less inclusive views of the different aspects of sick-listing (table 3) appeared to be less comfortable or outright distressed in their sick-listing role.

Study II, Orthopaedic surgeons’ views
Our intention was to analyse the same domains as for study I, if applicable. However, we found a limited extent of applicability. Only one, namely the view of the sick-listing commission, was found in this material. Instead, unexpectedly a domain regarding the orthopaedic surgeons’ role in the health care system emerged as the most fundamental in relation to sickness certification. Handling of discordant opinion on the need for sickness certification also emerged as an important domain for sickness certification practice among orthopaedic surgeons. The analysis was thus adapted to the finding of these emergent domains.
Table 3. *Combination of GPs’ views on different aspects of sickness certification*

<table>
<thead>
<tr>
<th>Responsibility for sick-listing and rehabilitation</th>
<th>Sick-listing commission</th>
<th>Sick-listing practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>(3a) Passive</td>
<td>(1a) Patient-certification</td>
<td>(2a) Issuing a certificate</td>
</tr>
<tr>
<td></td>
<td>Patient-certification</td>
<td>Issuing a certificate</td>
</tr>
<tr>
<td></td>
<td>Patient-certification</td>
<td>Issuing a certificate</td>
</tr>
<tr>
<td>(3b) Protecting</td>
<td>(1b) Patient-rehabilitation</td>
<td>(2b) Changing work situation</td>
</tr>
<tr>
<td></td>
<td>Patient-rehabilitation</td>
<td>Changing work situation</td>
</tr>
<tr>
<td></td>
<td>Patient-rehabilitation</td>
<td>(2d) Holistic view **</td>
</tr>
<tr>
<td>(3c) Authoritative</td>
<td>(1c) Society</td>
<td>(2c) Changing life-style</td>
</tr>
<tr>
<td></td>
<td>Society</td>
<td>(2b) Changing work situation</td>
</tr>
<tr>
<td>(3d) Supporting</td>
<td>(1b) Patient-rehabilitation</td>
<td>(2d) Holistic view **</td>
</tr>
<tr>
<td></td>
<td>(1c) Society</td>
<td>(2b) Changing work situation</td>
</tr>
<tr>
<td></td>
<td>Society</td>
<td>(2d) Holistic view **</td>
</tr>
<tr>
<td></td>
<td>(1d) Integrated*</td>
<td>Holistic view</td>
</tr>
<tr>
<td></td>
<td>Integrated</td>
<td>Holistic view</td>
</tr>
<tr>
<td></td>
<td>Integrated</td>
<td>Holistic view</td>
</tr>
<tr>
<td>(3e) Empowering</td>
<td>(1b) Patient-rehabilitation</td>
<td>Holistic view</td>
</tr>
<tr>
<td></td>
<td>(1c) Society</td>
<td>Holistic view</td>
</tr>
<tr>
<td></td>
<td>(1d) Integrated*</td>
<td>Holistic view</td>
</tr>
<tr>
<td></td>
<td>Integrated</td>
<td>Holistic view</td>
</tr>
</tbody>
</table>

(1a) *etc.* refers to view 1a *etc.* as numbered in the text

* Integrating society’s as well as the patients’ interests into one sick-listing commission

** Sick-listing as exploring and taking as many aspects as possible into account, i.e., work-related factors as well as life-style

No orthopaedic surgeon mentioned patients wanting to work when the doctor’s judgement was that the patient needed to be signed off sick.

**Orthopaedic surgeons’ role in the health care system in relation to sick-listing**

The orthopaedic surgeons’ views on good sickness certification practice were mainly related to their view on their role in the health care system. Three views or categories of description were found:

The *isolated specialist*, perceived his work and responsibilities to be confined to the orthopaedic clinic, and not really include sick-listing:

> I did sick-list her for quite some time, but finally I said […] if you want to get yourself an early retirement, you’ll have to go to your GP. I was nice to her for a while and gave her sickness certificates [even though there was no orthopaedic reason]. *(Dr B)*
I think it’s rather unpleasant [issuing sick notes], and [...] it’s difficult and it’s sort of our own [physicians’] fault that the level of sickness absence is high. *(Dr E)*

The orthopaedic adviser, who perceived him or herself mainly as an advice-giver in relation to the general health care and perceived sick-listing to be part of the job:

She started to cry and said “I can’t work when I’m like this.” And I said, “Well, I guess you’ll have to, because your body is fully functional, and having just a little pain can’t make you completely unfit for work.” And yet, she wasn’t satisfied; she had come on a referral note from a doctor. So I said that she would just have to go back to that doctor and discuss it with him. *(Dr J)*

The system integrated physician, who perceived the orthopaedic clinic as one part of the health care system and whose ultimate goal is to get the patient well functioning in her life again with regained work capacity, and viewed sick-listing as one of the instruments to achieve this.

But we usually just sort of pilot them through this injury period, and then I refer them to primary care. All [patients], where there is a problematic situation, that one really has to get into, to get them going again. And then I don’t extend their sick leave, but they get it from their GP. *(Dr S)*

**Discordant opinions on sickness certification**

There were three categories of handling discordant opinions on sickness certification.

*Directed by the patient*

Disagreements about the need for sick leave create internal conflicts for orthopaedic surgeons, who do not see how they can question patients' opinions without wasting time and emotional energy, and therefore let the wishes of the patients determine whether or not to issue a sickness certificate. The orthopaedic surgeons holding this view find sickness certification very difficult and unpleasant, and hence they want to get rid of their sick-listing commission. All of the respondents we call isolated specialists held this view, as did some of the system-integrated physicians.

It [not issuing a sickness certificate] costs too much time and energy. Mainly time I think—no both—kind of mental energy. *(Dr E, isolated specialist).*

A lot of times you end up in a conflict, not with the patient, but with your own ideas [...] it depends a lot on what the patients themselves think, and that’s frustrating when you’re dealing with sickness certification. [...] You can’t get patients back [to work] earlier than they want to themselves. It’s almost impossible. *(Dr D, system-integrated physician)*
Compromising
The orthopaedic surgeons try to compromise when their opinions differ from those of their patients regarding the need for sick leave. This view was expressed by all of the surgeons in the orthopaedic adviser category and also by a few of those in the system integrated category.

Sometimes you have to compromise so you won’t lose the patient’s trust completely. So it has to be a dialogue [with the patient], right, to get the patient to go back to work. (Dr O, orthopaedic adviser)

Directed by professional judgement
A sickness certificate should not be issued in contradiction to the professional judgement of the orthopaedic surgeon, even when the patient and the orthopaedic surgeon disagree on the need for sick leave. The reason for that is that the responsibility of the physician does not end with a good outcome of surgery, but instead extends to the long-term well-being of the patient. We found this view only among the physicians identified as having a “system integrated” view of their role in the health care system.

He [a car mechanic] had a healed forearm-fracture with no signs at all of reduced function. All he said was that he was in pain so he needed to be on sick leave. I told him I didn’t think it was good for him or any 24-year-old to stay at home and just hang around, that he really ought to go back to work or find another job. Then he got really mad and rushed out angry, and was rude. But I mean, (sigh), I’ve kind of learned to just shrug my shoulders, and after about four minutes I don’t think about it any longer. If you do that, most patients pull themselves together and go to work and get a normal life. (Dr A, system-integrated physician)

Study III, Barriers to good sick-listing practice
All the GPs talked about a number of different barriers that prevented them from practising what they perceived to be good sickness certification. Moreover, all the GPs talked about wanting to sick-list less, not more, and no GP mentioned patients wanting to work when the physician assessed a need for sick-listing. The barriers were categorised as being either within or outside the health care system (table 4). A few details will be highlighted:
Table 4. Barriers for good sick-listing practice according to 19 Swedish GPs

<table>
<thead>
<tr>
<th>I. Within health care</th>
<th>II. Outside health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical judgement, physician competence, communication skills in relation to patients – difficult to evaluate signs, symptoms and work capacity. Physicians lack competence in these areas and for handling situations with conflicting wishes, and patients with no incentive to work.</td>
<td>Societal attitudes to sickness certification and benefits – financial situation, reputation, a source of income with no loss of dignity</td>
</tr>
<tr>
<td>Other health care professionals – initiate sick-listing without planning how to end it; discourage patients from trying to resume work.</td>
<td>The labour market – few un-qualified jobs left for people with disadvantages like old age, poor language skills or low education, and physical ailments</td>
</tr>
<tr>
<td>Health system deficiencies – lack of time for physicians, long waiting times, poor continuity</td>
<td>Work environments – higher levels of work demands and little chance for people with some weaknesses to be employed</td>
</tr>
<tr>
<td></td>
<td>Private life – often the reason for the urge to be on sick leave</td>
</tr>
<tr>
<td></td>
<td>National insurance regulations – poor rehabilitation if the patient is not employed. Difficult to fill in rigid certification forms</td>
</tr>
<tr>
<td></td>
<td>Poor stakeholder collaboration with:</td>
</tr>
<tr>
<td></td>
<td>Other stakeholders</td>
</tr>
<tr>
<td></td>
<td>Social Insurance Office – does not make proper judgements, is slow, passive, difficult to access, lacks interested officers, lack or misuse of resources</td>
</tr>
<tr>
<td></td>
<td>Employers – lack of understanding, passive, refusing to adapt work, etc.</td>
</tr>
<tr>
<td></td>
<td>Occupational Health Services – often non-existent or without physicians</td>
</tr>
<tr>
<td></td>
<td>Employment agency and social welfare office – demand sickness certification for people who are not very sick to solve their own administrative problems.</td>
</tr>
</tbody>
</table>
Barriers within the health care system

Clinical judgement, physician competence, and communication skills

Difficulties in assessing the case history, signs and symptoms, work capacity, optimal length of sick leave, as well as in estimating the risks the sick leave might pose for the patient, were perceived to be barriers to good sick-listing practice. The lack of scientific evidence about the consequences of being absent on sick leave made sickness certification even more difficult. To some physicians, these difficulties were perceived as being attributable to their own insufficient competence and training.

A number of physicians seemed to have major difficulties handling situations where the patient’s demands for sickness certification were opposed to their own judgement. This resulted in physicians issuing certificates in contradiction to their own ideas of good practice. However, those physicians did not mention lack of skill in handling such situations as a barrier.

But in practice, you can’t deny anyone [sick-listing]. That possibility we don’t have, when we are sitting across from a patient. (Dr R)

Barriers outside health care

Poor stakeholder collaboration

Other stakeholders within the field of rehabilitation (employers, social insurance, unemployment and social welfare officers) were seen as not cooperative and the GPs often felt isolated.

We used to have a local rehabilitation group – our district has always been very progressive – it was the healthcare, sometimes occupational health services, sometimes the psychiatric care, always the Social Welfare Office, always the Social Insurance Office, always the Employment Service. We met approximately four, five times per term. It was great! But it stopped with the reorganisation of the Social Insurance Office. We are still suffering from the trauma of losing it. (Dr F)

Study IV, Emotionally straining problems

The proportion of physician at PHCCs and orthopaedic clinics who found it problematic to handle sickness certification and experienced conflict at least weekly was more that double that of physicians working elsewhere (table 5). More than half of all physicians found it fairly or very problematic to handle situations where physician and patient had different opinions on the need for sick leave. Among GPs the proportion was even larger (83%). Physicians working at PHCC had 3-5 times higher risk of experiencing all types of sick-listing problems compared to others, i.e. all physicians apart from those working at PHCC and orthopaedic clinics (table 6).
Table 5. Percentage of physicians reporting sick-listing problems at PHCCs, orthopaedic clinics, and other workplaces

<table>
<thead>
<tr>
<th></th>
<th>PHCCs¹</th>
<th>Orthopaedic clinics</th>
<th>Other workplaces²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=954</td>
<td>n=189</td>
<td>n=2864</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Finds it problematic to handle sickness certification at least 1-5 times/week.</td>
<td>60.1**</td>
<td>53.0***</td>
<td>22.8</td>
</tr>
<tr>
<td>Finds it very or fairly problematic to manage the double roles as the patient’s physician and medical expert for authorities</td>
<td>66.0***</td>
<td>39.2**</td>
<td>29.7</td>
</tr>
<tr>
<td>Finds it very or fairly problematic to handle situations where physician and patient have different opinions on the need for sick-leave</td>
<td>82.8***</td>
<td>58.5</td>
<td>53.6</td>
</tr>
<tr>
<td>Experiences conflicts regarding sickness certification at least 1-5 times/week</td>
<td>21.5***</td>
<td>15.6***</td>
<td>6.1</td>
</tr>
<tr>
<td>Worries at least once per month that a patient will report to the disciplinary board in connection with sickness certification</td>
<td>11.6***</td>
<td>5.3</td>
<td>2.8</td>
</tr>
<tr>
<td>Feels threatened by a patient at least once per month in connection with sickness certification</td>
<td>9.8***</td>
<td>4.8</td>
<td>3.1</td>
</tr>
</tbody>
</table>

¹PHCCs = Primary Health Care Centres
²Other workplaces than PHCCs or orthopaedic clinics
*p<0.05, **p<0.01, ***<0.001. P-values in second column refer to difference between PHCCs and other workplaces. P-values in the third column refer to difference between physicians at orthopaedic clinics and other workplaces.

Almost 83% of physician working at PHCCs compared to 54% of the physicians working at orthopaedic clinics and 58% of physicians at other workplaces find it very or fairly problematic to handle sickness certification at least 1-5 times per week. Physicians working at orthopaedic clinics also had a higher risk of experiencing different sick-listing problems, but with adjusted odds ratios this was significant only for experiencing conflicts and finding it problematic to handle sickness certification at least 1-5 times per week (table 6).
<table>
<thead>
<tr>
<th>Question</th>
<th>Workplace</th>
<th>Odds Ratio</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Crude (CI)</td>
<td>Adjusted¹ (CI)</td>
</tr>
<tr>
<td>Finds it <strong>problematic</strong> to handle sickness certification at least 1-5 times/week</td>
<td>PHCCs²</td>
<td><strong>5.1</strong> (4.4-6.0)</td>
<td><strong>4.9</strong> (4.1-6.0)</td>
</tr>
<tr>
<td></td>
<td>Orthopaedic clinics</td>
<td><strong>3.8</strong> (2.8-5.2)</td>
<td><strong>2.2</strong> (1.5-3.0)</td>
</tr>
<tr>
<td></td>
<td>Other workplaces³</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Finds it very or fairly problematic to manage the <strong>double roles</strong> as the patient’s physician and medical expert for authorities</td>
<td>PHCCs²</td>
<td><strong>4.6</strong> (3.9-5.4)</td>
<td><strong>4.6</strong> (3.9-5.5)</td>
</tr>
<tr>
<td></td>
<td>Orthopaedic clinics</td>
<td><strong>1.5</strong> (1.1-2.1)</td>
<td>1.2 (0.9-1.7)</td>
</tr>
<tr>
<td></td>
<td>Other workplaces³</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Finds it very or fairly problematic to handle situations where physician and patient have <strong>different opinions</strong> on the need for sick leave</td>
<td>PHCCs²</td>
<td><strong>4.2</strong> (3.5-5.0)</td>
<td><strong>4.3</strong> (3.6-5.3)</td>
</tr>
<tr>
<td></td>
<td>Orthopaedic clinics</td>
<td>1.2 (0.9-1.6)</td>
<td>1.2 (0.9-1.7)</td>
</tr>
<tr>
<td></td>
<td>Other workplaces³</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Experiences <strong>conflicts</strong> regarding sickness certification at least 1-5 times/week</td>
<td>PHCCs²</td>
<td><strong>4.2</strong> (3.4-5.3)</td>
<td><strong>3.8</strong> (3.0-4.8)</td>
</tr>
<tr>
<td></td>
<td>Orthopaedic clinics</td>
<td><strong>2.9</strong> (1.9-4.4)</td>
<td><strong>1.9</strong> (1.2-3.0)</td>
</tr>
<tr>
<td></td>
<td>Other workplaces³</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Worries</strong> at least once per month that a patient will report to the <strong>disciplinary board</strong> in connection with sickness certification</td>
<td>PHCCs²</td>
<td><strong>4.6</strong> (3.4-6.2)</td>
<td><strong>4.0</strong> (2.9-5.6)</td>
</tr>
<tr>
<td></td>
<td>Orthopaedic clinics</td>
<td><strong>2.0</strong> (1.0-3.9)</td>
<td>1.2 (0.6-2.6)</td>
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<td>Other workplaces³</td>
<td>1</td>
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<tr>
<td>Feels <strong>threatened</strong> by a patient at least once per month in connection with sickness certification</td>
<td>PHCCs²</td>
<td><strong>3.5</strong> (2.6-4.7)</td>
<td><strong>3.0</strong> (2.1-4.1)</td>
</tr>
<tr>
<td></td>
<td>Orthopaedic clinics</td>
<td>1.6 (0.8-3.2)</td>
<td>1.1 (0.5-2.4)</td>
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<tr>
<td></td>
<td>Other workplaces³</td>
<td>1</td>
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**Bold** numbers= significant values at p<0.05

¹ adjusted for sex, reporting support from management regarding handling of sickness certification, having a workplace policy for handling matters related to sickness certification, years of work, being a specialist in General Practice or any other specialty and seeing potential sick-listing-patients at least 6 times per week

² Primary Health Care Centres

³ Other clinics or practices than PHCCs or orthopaedic clinics
About ten percent of PHCC physicians worried about getting reported to the disciplinary board, or felt threatened in relation to sickness certification every month. The kind of threat was not specified in the questionnaire but up to the individual respondent’s interpretation.

Male physicians at PHCCs and at other workplaces had a 20-30% higher risk of finding it difficult to handle sickness certification at least 1-5 times per week as compared with female physicians. Female PHCC physicians, on the other hand, had a 40% higher risk of finding it problematic to have a different opinion from the patient on the need for sick leave. There were no other sex differences.

Physicians working in primary care who reported having a workplace policy on sick-listing had a reduced risk of experiencing conflicts regarding sickness certification 1-5 times/week (OR 0.6; 95% CI 0.45-0.9), and worrying of getting reported to the disciplinary board (0.6, 95% CI 0.4-0.8) or feeling threatened at least once per monthly (OR 0.4; 95% CI 0.3-0.6). Similarly, physicians working in other places than orthopaedic clinics and PHCCs who reported having a workplace policy had a reduced risk of reporting finding it problematic to handle the double role (OR 0.6; 95% CI 0.5-0.7) or situations with different opinions on the need for sick-leave (OR 0.7, 95% CI 0.6-0.8), see table 3 in paper IV

Summary of findings

There were qualitative differences in how GPs and orthopaedic surgeons perceived good sickness certification, within the two groups, and between them (study I and study II).

The orthopaedic surgeons’ perception of good sick-listing was related to their perception of their role in the health care system (study II), whereas the GPs’ role in the health care system was not even mentioned by the GPs, who tended to speak more directly about sickness certification (study I).

Some GPs exposed narrow views of sick-listing, where their responsibility was limited to issuing a sickness certificate on demand from patients, while others presented successively more inclusive views. In the most inclusive view the illness or injury hindering the patient from work was recognised in a perspective of the patient’s total life situation. All identified problems were perceived to be important to address, in order to rehabilitate the patient’s work capacity. These GPs’ perception of their responsibility is to help the patients to shoulder their responsibility for their own sick-listing and rehabilitation (study I).

Some orthopaedic surgeons perceived their work and responsibility as confined to the orthopaedic clinic only, while others saw as their ultimate goal to help the patient become well functioning in her own life, with a regained capacity to work. This could be promoted not only by surgery, but
also by proper management of the sickness certification instrument (study II).

Problems in relation to sickness certifications were reported to be more frequent among orthopaedic surgeons, and even more so among GPs, as compared with other physicians (study IV). Reporting having a workplace policy on sickness certification was associated with reporting of less problems in relation to sickness certification (study IV).

GPs perceived several barriers to sick-listing in line with their own views of good sick-listing practices, some barriers within the health care system, others outside (study III).

Many GPs and orthopaedic surgeons experienced problems in dealing with patients having ideas opposed to the physicians’ ideas on the need for sickness certification (studies II and III).
Discussion

There were substantial differences in how GPs and orthopaedic surgeons perceived sick-listing, within the groups as well as between them (studies I and II). Difficulties handling situations of contradicting opinions on the need for sickness certification seem to be common (study IV), and a barrier to good practice (III).

Different views - different practice?

In the phenomenographic studies of GPs and orthopaedic surgeons (studies I and II) there was substantial variation concerning how informants perceived sickness certification. Some displayed narrow views, taking few aspects into consideration, while others had more inclusive views, taking in a number of aspects. Do these different views on issues related to sickness certification reflect different behaviours or practices in relation to sickness certification?

The informants gave detailed descriptions of their behaviour in relation to specific sick-listing cases, which they chose from their own practice. They were encouraged to talk about the thoughts behind their actions and reflect on their behaviour. Their views on sickness certification are extracted from these narratives. In can therefore be assumed that there is a relation between their views and their behaviour.

The question whether GPs and orthopaedic surgeons with more inclusive views handle sickness certification in a more competent way – a way resulting in a better outcome – cannot be answered through this study. However, other studies support the hypothesis that more inclusive views are linked to more competent performance in practice. In a study of car engine optimisers at Volvo, those with a more inclusive understanding of their work were judged by their workmates and by the researchers as more competent on the job compared with other engine optimisers [38]. Similarly, in a study of medical students followed at medical school for 5.5 years, those with a broader view of medical practice displayed more competent behaviour in patient encounters as judged by the researchers [39].

It can be argued that a broad or more inclusive view, *i.e.*, a more comprehensive perception of sickness certification may be more useful than a narrow view (studies I and II). A broad view does not necessarily imply taking all aspects into account at all consultations, but being able to use the broad view when it is needed [37]. Physicians with a narrow view cannot take into
account more aspects even when it would be needed, because they do not perceive them – *i.e.* they are not aware that they exist.

**Changing practice**

Findings from empirical research [36, 38, 56, 87-90] demonstrate that comprehensive understandings of practice is infrequent in professional life. This indicates that refinement of existing understanding, rather than transformation to more complex understanding of practice, is likely to be the norm in the professions rather than an exception [39].

It has been argued that deep learning entails a shift in understanding, rather than increased accumulation of skills and knowledge, which is another but less powerful kind of learning [39]. How can professionals be supported to make such a shift in understanding? In the context of this study, how can GPs and orthopaedic surgeons be supported to shift to a more inclusive view of sickness certification?

Previous research has shown that individual physicians can adopt more inclusive views after an educational intervention [41, 42]. For such a change of perceptions to occur, the learner’s existing conceptions must be challenged [41, 95]. For a teacher to be aware of the critical variations of the phenomenon under study and help the learner become aware of a critical variation too, in order to perceive the phenomenon of interest in a new and more complex way, is the pedagogical challenge [37]. It has been suggested that interactive, emotionally engaging learning situations where dialogue is used are much more likely to achieve change of understanding than situations of one-way communication [100]. Simultaneous change of view and change of practice have been shown after an educational intervention [42], but it could not be shown that the practice changed *as a consequence* of the changed view.

**Barriers**

More than half of all physicians found it fairly or very problematic to handle situations where physician and patient had different opinions on the need for sick leave. Among GPs the proportion was even larger (study IV). In the interviews with GPs, difficulties in handling such situations emerged as a major barrier to what the GPs perceived as good sickness certification practice (study III). Also there were orthopaedic surgeons certifying sickness in contradiction with their professional judgement in order to avoid open conflict with patients (study II).

These findings are in line with previous research. In a British study of GPs’ management of acute back pain it was revealed that sickness certification constituted a considerable potential for conflict in the relationship [101]. In a Swedish study it was shown that obstetricians as a rule complied with
the pregnant women’s wish for sickness certification in order to avoid conflicts [25].

Among the interviewed physicians, none mentioned situations in which the patient wanted to work while the physician’s judgement was that the patient needed to be off sick (studies I-III). This is in contradiction with a British study of GPs, where the general opinion was that it was more common to find patients who returned to work or who wanted to return to work before the GP considered them fit to do so, than the opposite [102]. In one Swedish dissertation it was also shown that physicians found such situations problematic where patients did not want to be sick-listed [103]. However, that study was performed during autumn 1996, a time with very low levels of sickness absence in Sweden – among the lowest in 30 years (figure 1).

According to a review, there is strong evidence of positive effects of communication skills training for medical students and physicians [104], including more accurate history taking, more satisfied and less distressed patients, better patient adherence to treatment and behaviour changes, as well as improved physician wellbeing [79]. Communication skills training for physicians often deals with handling difficult situations [79, 104] that may require a similar set of skills as situations with conflicting opinions on the need for sickness certification. Communication skills training may therefore help physicians to sick-list in line with what they perceive to be good practice. According to the same questionnaire on which study IV is based, 40% of all studied physicians reported a large or a fairly large need for acquiring skills to handle conflicts with patients when dealing with sickness certification, while the corresponding figure for GPs was about 60% [105]. Thus there seems to be both awareness and demand among physicians for training in communication skills.

Another barrier was poor collaboration with other stakeholders. Difficulties collaborating with the social insurance office has been reported previously [6, 22, 23, 60]. On the other hand, achieving multisectorial collaboration has been shown to successfully decrease the number of sick-leave days generating substantial economic gains for society [106].

The double role

The double role as the patient’s physician and that of an expert in relation to the authorities in sickness certification matters was perceived as more difficult by PHCC physicians compared to other physicians (study IV). In the qualitative studies, too (studies I, II, III), this double role was perceived as difficult.

The “double role” has also previously been reported to be difficult for GPs [5, 21, 22, 23, 107]. One explanation for PHCC physicians experiencing the double role as more problematic than others could be that, compared to hospital physicians, they more often perceive themselves as treating the
whole person, rather than a sick or injured body part [24]. It is worth noting that some GPs had found ways of handling this inherent conflict (study I).

Threats

Feeling threatened by patients in relation to sickness certification was not uncommon. Ten percent of GPs reported feeling threatened monthly (study IV). However, among the interviewed GPs (study I) only one spoke explicitly of being threatened by a patient, which can be due to the fact that the GPs were not specifically asked about threats. In the literature reports on threats, especially verbal abuse, are not uncommon [108-112]. However, there is no information regarding the extent to which these instances might have been triggered by sickness certification issues. It should be noted that aggression toward physicians is not restricted to GPs, although most studies to date have been on GPs or emergency room personnel [113].

Differences between female and male doctors

There were few and small differences between female and male GPs in the study, but it is interesting to note that all GPs who had “solved” the conflict between society’s and the patient’s sick-listing commission in study I were women. However, as this was a qualitative study with only 19 informants (nine female), it is not possible to draw conclusions on the sex distribution of lack of conflict between society’s commission and that of the patient’s. It can only be said that there might be such a difference and that further research is warranted.

In the survey there were also few and small sex differences (Study IV). In the interview study with orthopaedic surgeons the very uneven sex distribution (mirroring reality) made comparisons between females and males impossible (study II).

A number of studies of physicians have shown differences between female and male physicians regarding sick-listing behaviour [4, 8, 33, 114], while others have not [34, 115, 116]. The findings in this study mirror these contradictions.

Workplace policy

Physicians reporting having a workplace policy also reported sickness certification problems to a lesser extent than those who did not report such a policy. However, we do not know what the respondents include in the concept of “workplace policy”, which could vary from assumed shared values to detailed, written policies, carefully worked out and agreed on – a kind of local guidelines. It has been argued that providing an institutional support mechanism in the form of local policy guidelines is good for the staff when
dealing with difficult cases [117]. Our findings (study IV) support the ben- 
ess of local policy guidelines for all physicians, apart from those at orthopae- 
dic clinics.

Methodological considerations

This study has mainly been concerned with GPs and orthopaedic surgeon. The views these two groups exhibit on sickness certification differ between and within groups. This can not be generalised uncritically to other groups of physicians.

It has been argued that physicians interviewing physicians poses both special problems and advantages in the interview situation [118]. For in- 
stance, the interviewee may feel that he or she is "on trial". On the positive side, a physician is seen as an equal, while physicians do not always readily accept people from other professions [118]. Since the questions posed to the informants in this study (studies I - III) did not include any questions on knowledge it is less likely they felt "on trial".

Phenomenography

Having analysed the GPs’ views on different domains of sick-listing, we explored how views on the three domains were combined in the individual informants (study I, table 3). We do not know of any other phenomeno-

graphic study where this has been done. We think this additional analysis added some interesting aspects concerning how GPs perceive the phenome-
non under study. There is no simple picture – the understanding of one do-

main, for example, does not exactly predict the understanding of another. If it had, we could have presented our findings without splitting the presenta-
tions into different domains. However, there was a tendency for the more inclusive views to go together, and for the less inclusive views also to do so.

Rigour in qualitative studies

In the qualitative studies (studies I – III) rigour was maintained throughout the research process using a range of strategies that included requesting con-
crete examples as evidence of claims made, actively seeking inconsistencies, and interpreting statements in context. Everything was also read from the perspective of a plausible alternative interpretation. These strategies are in line with Kvale’s [119] communicative and pragmatic validity as well as aiming for reliability though the researchers’ interpretative awareness [36]. A further phase in establishing rigour involved selection of quotations to support the analysis. From this stage on, the research community becomes
involved in determining the extent to which results are convincing as well as in making judgement about how well the research has been carried out [40].

Survey questionnaire
Using a cross-sectional questionnaire design in study IV allowed us to contact many physicians. However, as always in cross-sectional study design, it did not give us the possibility to draw causal conclusions [120], but only to demonstrate associations.

A response rate of 71% can be considered high for a study of physicians. Postal surveys to physicians are known to often give low response rates [121-124]. The non-respondents did not differ regarding the two participating counties or between men and women. Other characteristics of the non-respondents are unknown, which is a limitation. Physicians working in these two counties represent approximately one fifth of all Swedish physicians of working age [3], and included physicians working in municipalities with both high and low levels of sickness absence [15] allowing for careful generalizations beyond the immediate areas studied. This is by far the largest population ever studied in this field.

Although all data were *self-reported*, there is no reason to believe that recall bias or the mode of responding to the questions would differ between the three groups of physicians analysed.

Triangulation
The use of both qualitative and quantitative techniques as a form of triangulation supports the validity of the findings. Handling situations where GPs and patients have different opinions on the need for sickness certification came up as a barrier in the qualitative study using content analysis (study III). In the questionnaire study (study IV) many physicians found handling situations where physicians and patients have different opinions on the need for sickness certification problematic. Despite very different research approaches the findings were thus similar.

Another kind of triangulation – researcher triangulation – was also used in these same two studies (studies III and IV) where one of the researchers was a social worker and insurance medicine researcher, while two others were physicians with different areas of specialisation, one of them also a health systems researcher, while a fourth member was a statistician (study IV).
Conclusions

This thesis has shown that:

- GPs and orthopaedic surgeons perceive sickness certification differently (studies I and II).
- Some GPs have narrow views of sick-listing, and consider their responsibility limited to issuing sickness certification on demand from patients, while others present more inclusive views (study I).
- GPs with the most inclusive view had a perspective of the patient's total life situation and aimed to help the patients shoulder their own responsibility (study I).
- The orthopaedic surgeons’ perception of good sick-listing was mainly related to their views on their role in the health care system (study II).
- Some orthopaedic surgeons perceived their work and responsibility as confined to the orthopaedic clinic only, while others saw their ultimate goal as helping the patient become well functioning in his or her own life, with regained work capacity, which could be promoted not only by surgery, but also by proper management of the sickness certification instrument (study II).
- Reporting a workplace policy on sickness certification was associated with reporting fewer problems in relation to sickness certification (study IV).
- About ten percent of GPs experienced threats or were worried about being reported to the disciplinary board at least monthly (study IV).
- Difficulties handling conflicting opinions on the need for sickness certification seemed to be a barrier to good sick-listing practices (study III) and were common, especially among GPs (study IV).
Recommendations

The different views on sickness certification among GPs and orthopaedic surgeons need to be considered when designing interventions aiming at changing the practices of GPs and orthopaedic surgeons.

Promoting a policy on sickness certification at the workplace may reduce physicians’ sick-listing problems. Systematic studies on whether and which workplace policies to promote are suggested.

The reasons for, and nature of perceived threats among GPs in relation to sickness certification need to be elucidated.

Communications skills training in relation to sickness certification could be useful and should be implemented in ways that could be evaluated. Such studies on communication skills training in relation to sickness certification are suggested for future research.
I am grateful to:

- **All participating physicians** who bothered to tell me about their sick-listing cases or to fill in the long questionnaire, and to **Eirs 50 års stiftelse**, **Filip Lundbergs stiftelse**, **Uppsala läns landsting**, **Olle Hööks fond** and **Minnesfonden** which all contributed to this research work.

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- **Jörgen Borg**, my co-supervisor, for being helpful in registering me as a PhD student and being encouraging along the way.

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- **Kristina Carlsson**, for helping me to see that my view was not abnormal when peer pressure was high.
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Our children Holger, Björn, and Harriet for being the best things that happened to me.

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And foremost those I forgot to list and should have.
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Annex 1, Interview guide in English

Interview guide (translated from Swedish)

GENERAL
1a What comes to your mind when you hear the word “sick-listing”?

PRACTICE – HAPPY
2a Please tell me about a resent patient where sick-listing was considered – a case where you feel happy about the way you handled it?

Do you have any other example where longer time sick-listing was at risk?

2b What was your goal with this sick-listing?
In general what is your goal when sick-listing?
2c Which alternatives did you consider when deciding whether sick-listing this patient or not?
In general how do you look upon different alternatives when sick-listing?
2d What did you tell the patient about the actual sick-listing, in this case?
What do you normally say about the sick-listing, when prescribed?
2e What is your view of the role of the patient in this case of sick-listing?

PRACTICE - LESS HAPPY
3a Please tell me about a recent patient where sick-listing was considered – a case where you feel less happy about the way you handled it?

Do you have any other example where longer time sick-listing was at risk?

3b What was your goal with this sick-listing?
In general what is your goal when sick-listing?
3c Which alternatives did you consider when deciding whether to sick-listing this patient or not?
In general how do you look upon different alternatives when sick-listing?
3d What did you tell the patient about the actual sick-listing, in this case?
   What do you normally say about the sick-listing, when prescribed?
3e What is your view of the role of the patient in this case of sick-listing?

**REPRESENTATIVENESS**
4a The two examples you have given, are they representative of your day to day experience, when it comes to sick-listing?

**THE COMMISSION**
5a How do you look upon your commission to sick-list?
5b At whose commission do you feel you are acting?
5c Who gave you this commission?
   How do you weigh the health benefits of sick-listing against the risk of unwanted side effects?

**THE IDEAL**
6a When sick-listing, do you ever feel you would like to act in a different way than you do, and in that case why?
6b In what way would you like to act differently?

**OBSTACLES**
7a Is there anything making things more difficult for you when trying to sick-list the way you would prefer? If yes, which?

**CONCLUDING GENERAL QUESTION**
8a Is there anything else you would like to add about sick-listing or any aspect of sick-listing?

Question “a” (1-8) were posed to all interviewed GPs
Probing questions “b” to “e” asked when more information was wanted
Annex 2, Questions used in study IV

Questionnaire on physicians’ sickness certification practices

(Additional questions were also posed on the same occasion, but these were not then used in the study)

Tick only one box for each question, unless otherwise indicated.

1. a What is your highest level of medical education?
   - □ Medical degree
   - □ Registered physician
   - □ Resident (In resident training)
   - □ Specialist

1. b How many years have you practiced medicine since you got your medical degree?

   Number of years
   [ ] 1
1. c In what areas do you have or are you undertaking specialist training?
Choose one or more options.

☐ General practice
☐ Occupational health
☐ Gynaecology/Obstetrics
☐ Internal medicine
☐ Surgery
☐ Oncology
☐ Orthopaedics
☐ Psychiatry
☐ Rehabilitation medicine
☐ Other (can be specified on the last page of the questionnaire [p. 8])
☐ None
1. d At what type of clinic/practice do you do mainly work?

Choose only one.

☐ Occupational health service
☐ Social Insurance Office (SIO) or Insurance Company
☐ Gynaecology/Obstetrics
☐ Internal medicine
☐ Surgery
☐ Addiction medicine
☐ Oncology
☐ Orthopaedics
☐ Psychiatry
☐ Rehabilitation care
☐ Primary Healthcare Centre
☐ Other (can be specified on the last page of the questionnaire)
☐ None
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<th>How often in your daily work do you…</th>
<th>More than 20 times a week</th>
<th>6–20 times a week</th>
<th>1–5 times a week</th>
<th>About once a month</th>
<th>A few times a year</th>
<th>Never or almost never</th>
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<td>2</td>
<td>a have consultations including consideration of sickness certification ⇒ <em>if you mark “never or almost never” go to item 11</em></td>
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4. How problematic do you find it …

4. f to manage the two different roles as the patient’s physician and medical expert for the social insurance offices and other authorities?

4. i to handle situations in which you and a patient have different opinions about the need for sickness absence?

10. Do you have support from your management regarding handling of sickness certification cases?

☐ Yes, to a large extent
☐ Yes, to some extent
☐ No

11. Does your clinic/practice have a common strategy for handling matters related to sickness certification?

☐ Yes, and it is well established
☐ To some extent
☐ No
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Editor: The Dean of the Faculty of Medicine

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