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## **Title**

Medical certification of work absence due to pain. A qualitative study of General Practitioners' and chronic pain patients' beliefs about the negotiated process of 'sick-listing'.

## **Abstract**

Many people absent from employment due to ill health would have better outcomes by working. Attempting to reduce sickness absence, the UK government is promoting the health benefits of work, to change doctors' and patients' behaviour. They created a national educational programme and replaced the medical statement known as the 'sick note' with the 'fit note', focusing on capacity. Much is known about sick-listing and also about chronic pain, but we lack knowledge of sick-listing for chronic pain patients and policy implications for this. In our qualitative study we interviewed 13 doctors and 30 chronic pain patients to explore their experiences of sick-listing and consider their views of the new policies.

Our findings reveal tensions in the doctor-patient relationship as sick-listing is negotiated. The indeterminacy of chronic pain renders the biomedical approach to diagnosis and capability decisions problematic; patients struggle with the performative aspect of sick-listing. Moral, socio-cultural and practical factors are invoked by doctors and patients to contest decisions. Both groups support the fit note's focus on capacity, but doubt it will overcome difficulties arising in consultations. Doctors value tacit skills of persuasion through negotiation that can change how patients conceptualise their illnesses and what constitutes an appropriate response. Policy-makers are coming to recognise that this tacit knowledge has a role to play in improving sick-listing. Our findings support this shift as we conclude that sick-listing can be improved by further consideration of doctors' negotiating skills.

## **Keywords**

Pain, doctor-patient relationship, sick-listing, fit note

## **Introduction**

Medically certifying permission for temporary absence from work, known colloquially as 'sick-listing', is a daily, challenging occurrence for UK primary health physicians (General Practitioners or GPs) (Wynne-Jones et al., 2010a). Sick-listing can be a powerful intervention for common health problems (Waddell and Burton, 2004), providing necessary periods of recuperation and state-sanctioned entry to the sick role (Parsons, 1951). Yet sick leave can also increase disability, extending the sick role unnecessarily (Waddell and Burton, 2004), resulting in poor health outcomes for patients, and considerable expense for tax-payers and employers (Black, 2008). Sick-listing rates have risen greatly in the UK since 1970, particularly for minor mental health problems and musculoskeletal disorders (Wynne-Jones et al., 2010b). Sickness certification is therefore seen as a social and economic policy issue as well as something that should be changed for the benefit of patients' health (Black and Frost, 2011). The UK government responded to rising rates with several policy interventions, most notably changing from sick to fit note in April 2010, replaced by an electronic version by late 2013 (DWP, 2013a). They created a national education programme for GPs, patients, Occupational Health (OH) professionals, employers and employees.

The first of these UK policy interventions is formally known as 'the statement of fitness for work', and colloquially as the 'fit note'. It focuses on capacity rather than incapacity and aims to return more people to work via temporarily reduced or revised duties. GPs can still classify

patients as 'not fit for work', but the alternative category of 'fit for work' has been re-worded to state that patients 'may be fit for work taking account of the following advice'. Four options follow: a phased return to work (RTW), amended duties, altered hours and workplace adaptations.

The second policy intervention is the national education programme comprising online and paper resources for stakeholders, summarising evidence that 'safe and accommodating' work is good for the health and wellbeing of most people, and that employees do not have to be 100% fit to return to work (Waddell and Burton, 2006: p.ix). Waddell and Burton's review concedes that a minority of people may experience contrary health effects and be better off not working, depending on the nature and quality of particular jobs, and recognises the need to take into account people's social contexts. While the evidence suggests that *most* patients are better off at work, these caveats make it difficult to know with certainty whether a *particular* patient would be better off at work. Government policy initiatives to reduce sick-listing diminish these caveats and appear to be largely based on a knowledge deficit model. They suggest that if GPs and patients were given more information about the health benefits of work, then sick-listing rates would reduce, as more patients would want to remain in work and GPs would find it easier to persuade reluctant people to return (DWP, 2012). The Department for Work and Pensions (DWP) has traditionally emphasised the need to equip GPs with knowledge about medical conditions and workplaces and diminished the skills needed to proactively manage sick-listing (Sawney, 2002). The original DWP fit note guidelines focused on correct form completion (DWP, 2012), rather than providing advice on the negotiation and communication skills which doctors need for sickness certification consultations (Gabbay, 2010). The original government guidance highlighted the positive effects expected from the fit note, i.e. that GPs would sick-list

less (DWP, 2012), but said little about tacit skills such as negotiating required for its effective use.

The information deficit model implied in the above policies can be characterised as 'naive rationalist' (Russell et al., 2008), although more recently the policy debate has begun to recognise the importance of GPs' negotiation skills. For example, government guidance has recently been revised, and is further forward on this trajectory, outlining how the fit note can guide discussion about challenging patients' perceptions of workability (DWP, 2013b). Additionally, the Royal College of General Practitioners (RCGP) runs the HealthyworkingUK website for GPs (RCGP, 2012), which includes e-learning modules on patient-practitioner communication and how to make difficult workability decisions, recognising these can be challenging issues.

The limitations of the naïve rationalist approach are further highlighted when considering non-specific or medically unexplained symptoms (MUS), of which chronic pain is a good exemplar. Gatchel and Turk (1999) argue that chronic pain should be viewed as a complex, interactive and psycho-physiological set of behaviours; Von Korff and Miglioretti (2005) suggest that it is better characterised as a dynamic rather than static state, as its severity fluctuates. Sick-listing for chronic pain is problematic because the uncertain nature of some chronic pain conditions means that doctors cannot always use the biomedical model to explain and manage, and it can be harder for GPs to assess how patients' capability for work is affected (Larsen and Jenkins, 2005). This indeterminacy is common to other MUS which form a core part of general practice (Salmon et al., 2007), suggesting that chronic pain is a good exemplar of how uncertainty renders capability decisions challenging (Hussey et al., 2004).

There is an established body of literature considering how doctors manage sick-listing, both in general (Hussey et al. (2004); Wynne-Jones et al. (2010a); Wynne-Jones et al. (2010c) and also specifically with regard to musculoskeletal disorders (Alexanderson and Norlund (2004) Werner and Cote (2009) Werner et al. (2012)). These studies conclude that sick-listing is problematic for doctors, whose role as gatekeeper conflicts with that of patient advocate. Doctors will negotiate with patients, but privilege the doctor-patient relationship above making a purely objective capability decision. Strikingly, Wynne-Jones et al. (2010a) report that conflict over sick-listing (for all conditions) is a weekly occurrence for GPs, indicating the magnitude of the problem. The chronic pain patient's experience of sick-listing is less well documented, although there are some studies, notably a systematic review of patient expectations of treatment for back pain (Verbeek et al., 2004) which reported that patients explicitly wanted sick notes. In contrast, Coole et al. (2010) found that lower back pain patients felt frustrated by GPs who immediately offered to sick-list them when they wanted to keep working.

Only so much can be understood by examining the knowledge, beliefs and expectations that doctors and patients *bring* to a consultation, because sick-listing is also affected by how stakeholders construct meaning through interaction *within* the consultation. There is some evidence that sickness certification for chronic pain conditions is not simply an unmediated response to physical pathology but a social process, to which the generation of shared meanings is central. These meanings may reflect legislation about who should and should not be sick-listed (Arrelöv et al., 2003) as well as normative expectations regarding what is and is not an acceptable reason to be sick-listed (Meershoek et al., 2007). Few studies have examined both doctors' and patients' responses to sickness certification negotiations within the same

piece of research, and so we wanted to explore the social negotiation of meaning within the sick-listing consultation for chronic pain.

We also wanted to learn more about doctors' and patients' views of the fit note and the UK national education programme, particularly whether it was thought these initiatives might improve sick-listing. Cohen et al. (2012), who deliver training as part of this programme, reported early findings of doctors' positivity; we could not find other studies about the national education programme. Hann and Sibbald (2011) found that 61% of doctors reported positive impacts of the fit note on the quality of consultations although 38% reported no change. Those who had received training reported more confidence in dealing with RTW, but there was no significant association between training and reporting positive fit note impacts. Fylan et al. (2011) reported doctors found the fit note useful for musculoskeletal conditions which could be helped via modified duties but were concerned about their accountability if a patient's health deteriorated upon RTW. We wanted to find out more about doctors' views on the fit note in relation to how they construct meaning within the consultation. There is little research on patients' view of the fit note, so we also wanted to study this further. This investigation was part of a larger study, and one aspect (GPs' views on the fit note) has been reported elsewhere (reference X), but what is reported here is new.

## **Methods**

Our assumption is that sickness certification is a socially negotiated process through which actors come to invest their experiences with meaning, thus our approach lies within the broad domain of symbolic interactionism which is concerned with how social order is maintained at the micro level of interaction in everyday life (Blumer (1986); Mead (1934); Jeon (2004);

Starks and Brown Trinidad (2007). Structural factors and previously existing narratives are important, but only as part of a dynamic process in which meanings are negotiated, shared and reworked. These ontological assumptions have epistemological consequences. Direct observation of consultations lay beyond the scope of the study, but we still wanted to access the different ways in which sickness certification for chronic pain is experienced and made sense of by patients and doctors, and to capture a sense of how these meanings are generated, contested and negotiated. We judged qualitative interviewing to be the most effective way of accessing these meanings. The research was informed by Grounded Theory and the assumption that there are categories which help us to understand individual realities, which make the shared creation of social reality possible and observable. There are different schools of grounded theory methodology (Charmaz and Henwood (2008); Corbin and Strauss (2008); Glaser and Strauss (1967); Strauss and Corbin (1990). Charmaz (2006) argues that there are so many schools that Grounded Theory Methods (GTMs) is a useful term for a collection of different methods with some similar principles. We chose the constructivist branch of GTMs following Charmaz (2006) as we took the position that data are generated by research not merely collected and that we can offer only an interpretation of them. We attempted to be reflexive and minimise bias, for example by different researchers checking coding.

### **Sampling and participants**

We used purposive sampling to select information-rich participants (Patton, 2002). We collected data until saturation occurred i.e. until new data failed to generate new theory (Glaser and Strauss, 1967). Charmaz (2006) emphasises that this does not mean simply pattern repetition but rather when no new theoretical insights into the main analytical categories emerge.



Participants were recruited in two groups: practising GPs, and chronic pain patients who wanted a sick note or had been offered one within the last year. Thirteen GPs from 11 practices in the south-west of England were recruited at three GP training events and at GP practice meetings. Thirty patients were recruited by: displaying posters in surgeries in south-west England; by EW attending regional pain management services; and by placing a study advertisement on UK pain charities' websites. The response rate for the pain clinics was 23.6%. Three GPs and two patients withdrew prior to consenting; no-one withdrew after.

There is some evidence that data saturation often occurs at around 12 interviews (Guest et al., 2006) and saturation occurred among the GP group after 13 had been interviewed. However, patients' experiences were more diverse and we judged that thematic saturation was not reached until 26 had been interviewed. Four more patients had already given informed consent, and it was unethical not to interview them once they had invested in the study materials, so 30 patients were interviewed in total. The data of the last four were useful in confirming that saturation had been achieved.

All participants had to be at least 18 years old and judged by the research team as capable of giving informed consent, and able to understand English adequately without an interpreter. All who expressed an interest in the study met these main criteria. GPs were not screened as there were no other exclusion criteria for them. Patients were screened to ensure they met the following inclusion criteria:

- be in employment and have needed a sick or fit note within the last year, or be on sick leave and require notes for wage replacement benefits

- have consulted their GP in the last year
- have experienced pain that had lasted for over 3 months within the last year
- consider that chronic pain was the major reason for sick-listing

All participants were sent information packs at least a week before interview, to allow sufficient time to decide whether to participate. Any participant queries were discussed, and written informed consent was received prior to interview.

### **Procedure**

Semi-structured interviews were chosen to encourage participants to raise issues that were salient to their experiences, generating rich, in-depth data (Denzin and Lincoln, 1994).

Interview questions were developed to explore:

1. How a doctor decides if a chronic pain patient needs sick-listing
2. What chronic pain patients consider when deciding if they need sick-listing
3. Doctors' and patients' awareness of and views on the Government education programme that work is beneficial for many patients' health outcomes, and also on the new fit note

The questions were designed to reflect a symbolic interactionist approach i.e. to elicit information about respondents' experiences of the meaning of events. For example, one of the doctors' questions under topic 1 was "How do you make sense of whether or not your patient should be signed off?"

A pilot study with two doctors and two patients was conducted. All interviews took place following the introduction of the fit note in April 2010 until October 2010. Field notes were written

after each 60 minute interview, recommended by Patton (2002) and Charmaz (2006). No participants were paid. Participants were offered the option of being interviewed face-to-face or by telephone. Twenty-seven patients were interviewed by telephone whereas interviews with all doctors were conducted face-to-face in their surgeries.

### **Analysis**

Interviews were audio recorded, transcribed and coded. GTMs principles were used to analyse the data Charmaz (2006). One researcher used open coding to generate potential codes, accompanied by verbatim quotations. Constant comparison was used to interrogate initial codes, organising them into analytical hierarchies until core categories were established. A second researcher took a selection of the quotations and categorised them into the previously identified core concepts. Differences in interpretation were discussed until consensus was reached. NVivo 8 software was used to organise the analysis.

### **Ethical approval**

NHS ethical approval was given by: X Local Research Ethics Committee, reference 09/H0101/72; the School Research Ethics Approval Panel of the School for Health, and the Department of Psychology Ethics Committee, University of X.

### **Results**

Data analysis revealed three core themes. Firstly, for doctors, the main issue was the double uncertainty of managing the MUS attending many chronic pain conditions, coupled with mapping these onto capability decisions. Secondly, for patients, sick-listing was perceived as a struggle to achieve state-sanctioned legitimacy. For both parties, these issues disrupted ideal

doctor-patient roles. Thirdly, doctors and patients agreed with the rationale behind the policy initiatives, as they believed in the health benefits of work, but found it problematic to apply this to some of their own situations, which they believed had particular elements not accounted for by the general principle that work is good for us.

We will now look in detail at issues that arose within each theme. We have structured our first two themes by focusing on doctors' views, then separately on patients', as their experiences of what it is to be a doctor or a patient were salient, although commonalities such as role disruption are discussed. For our third topic (views on policy) we have discussed both parties' views together, as the overarching theme was of the difficulty of applying an agreed principle in practice.

### **The doctor's dilemma: double uncertainty**

Many symptoms encountered in general practice, including chronic pain, cannot easily be explained by observable physical pathology, so doctors used less objective criteria, such as patient report and presentation of symptoms:

*'Building up experience of patients' enactment, is how we benchmark the particular patient's pain in front of us...some patients hunch and guard and some have learned to accept [their pain] so it's harder to gauge their level of pain'* [GP11]

Many doctors reported that assessing patients' enactment of pain was challenging and uncertain: *'in the end, it comes down to the patient, and some aren't as eloquent as others'* [GP8]. This led to *'intellectual discomfort'* [GP 6] for some doctors as they were uncomfortable having to make capability decisions without firm evidence of pathology. Uncertainty about

diagnosis was compounded by ignorance of the patient's working conditions and this double uncertainty rendered decisions about capability for work challenging:

*'It's extremely difficult [to make the capability decision] because you can't see somebody's pain. Quite often the patients just bounce into the surgery and don't look like they've got pain at all. And that's – they're the problem ones. They say they've got agonising back pain and they can't possibly work, but there is no objective evidence for it.'* [GP2] and *'The trouble is, of course, as a GP, I don't necessarily know much about their work'* [GP6]

Even doctors with OH qualifications reported that:

*'There's factories and factories or there's shops and shops, and some shops have nice, wide, light, airy aisles and every manual handling device you can imagine whereas in the charity shop you go up and down three flights of twisting stairs, carrying boxes'* [GP13]

In response to uncertainty doctors valued *'listening to the patient'* [GPs 1, 11 and 13] and trusting what they said about their job. Most doctors trusted most patients' accounts: *'I don't think people set out to mislead us actually, it's not in their interest'* [GP13] but also said a minority of patients' descriptions of their jobs could be skewed: *'There are some patients who basically have jobs that they didn't like at the best of times. And that's where the problem lies really, the motivation to return is poor.'* [GP9]. In these cases, sickness certification can be used to allow both parties to feel (at least superficially) that the consultation has been successful. The doctor may give the note, but with provisos, such as making the absence period short. The note is then symbolic of the doctor listening to the patient and acting sympathetically. The

'achievement' [GP11] of obtaining a sick note can enable patients to believe that their illness has been validated and that their absence from work is legitimate, but doctors often reported dissatisfaction with the lack of objective evidence behind the decision and were concerned that treatment options were limited and often ineffective, leading to unsatisfactory outcomes:

*'There's just nothing that we can really offer people other than X [a tertiary level pain management service] and let's face it X is very oversubscribed. The trouble is, once they've been through that system, they come out the other side and maybe they're better for a bit but inevitably they come back here again and then what do we do? You know, there's no on-going input.'* [GP8]

Withholding a sick note could generate conflict with the patient which disrupted the Parsonian ideal of the caring, sympathetic doctor:

*'I certainly don't think it's right for GPs to put themselves in the position of judgement and it's amazing...the percentage of patients who feel threatened by that, and I feel uncomfortable that we need to do it, to some degree'* [GP5]

Other doctors related their unwillingness to refuse a note to their conviction that they need to privilege their on-going relationship with patients:

*'I think ultimately if they want a note, they'll get it. I might try and persuade them back to work and advise them that perhaps it's in their interest but there are some people who are determined to have it and then I don't see it as our job to stop that. I know that they'll be*

*assessed by a benefits doctor and they're not looking for a long-term relationship with the patient or the rest of their family. I suppose I would begrudgingly give the note in the knowledge that there's another doctor who's independent and doesn't have that long-term relationship who will actually make a judgement as to whether they're fit or not'. [GP13]*

Some doctors were more assertive, managing to set targets whilst still maintaining that they would not refuse to sick-list:

*'I would never refuse a note as then we get into a situation of conflict and that's no good for anyone as someone has to back down and lose face. It's about managing expectations. I would give shorter and shorter notes and I'd say in one consultation that the next note would be shorter so I'm setting up that situation.'* [GP10]

Strategies discussed by doctors included writing to employers to try to get targeted support for patients (which got little response), and emphasising the health benefits of work, but notice also the reference to 'managing expectations' suggesting an active process of re-negotiating meanings.

Doctors believed that the Government is asking them to police the benefits system whereas that is not what doctoring should be about. Such policing involves making moral judgements with which doctors felt uncomfortable. An *in vivo* code '*I'm not a health policeman*' [GP8] encapsulated this and many doctors said they were the patient's advocate and that: '*I'm not going to send them back if I think that will make them worse, whatever the DWP or anyone else says*' [GP4]

The uncertainty entailed in sick-listing for non-specific complaints elicits a range of different responses from doctors: acquiescing to the patient's wishes; attempting to impose provisos; attempting to produce a change in expectations; or simply washing their hands of what they see as a policing role. Adoption of these strategies is often accompanied by feelings of dissatisfaction.

### **Patients' experiences of sick-listing: a struggle for validation**

The uncertain nature of chronic pain made sick-listing consultations challenging for patients as well as doctors; most were confident they would eventually get a sick or fit note if they wanted one, but often felt delegitimised by the process:

*'I must admit I have routinely, over the last six years, made damn sure somebody does see me when my back is bad, because I think it's just too easy to, you know, wait till you're better and then go down the doctors'. I talk to fight, if you know what I mean. But then you realise underneath, actually I wish I wasn't fighting'* [patient 1]

Patients are often aware that the legitimacy of their complaint can depend upon how they present their symptoms to the doctor, but the intermittent nature of chronic pain, coupled with the need to wait for an appointment, mean that they often present when their symptoms are in abeyance. On these occasions the patient is obliged to enact the severity of their condition to persuade the doctor that they are genuinely ill: *'Unfortunately the system makes people do that, you've got to demonstrate your worst days'* [patient 1]. Having to (re)enact their symptoms in order to obtain a sick note is a risky strategy. If the performance is not convincing it might be



read as evidence of illness deception or malingering. Even if the performance is convincing it may leave the patient feeling that they have engaged in a kind of fiction.

Patients often believed that their reports and enactments of their pain were not fully trusted by doctors, giving rise to a mutual process of scrutiny in which the doctor surveys the patient for any clues as to the authenticity of the illness and the patient returns the doctor's gaze for signs that they have not been believed:

*'I didn't like my GPs before – I just didn't like the face that they pulled, like, 'Oh, again'. They would do the note but I would leave their practice with a very guilty feeling and I was feeling like a criminal sometimes. You know, it [the pain] was real...I looked healthy, but it was true'* [patient 6].

Others reported that the problem lay not so much in the doctors' lack of comprehension, but in the intrinsic difficulty of communicating the subjective experience of pain: *'Well, I couldn't describe it properly, in terms of how the GP understood'* [patient 10]. Most patients said that their knowledge of the workplace was accepted by doctors, as both parties in the consultation knew doctors were unlikely (and could not be expected) to know the specifics of individual patients' jobs. However, patients believed that employers did not trust them, so patients pushed doctors to sick-list as well as to write medical diagnoses on notes, to reinforce patients' lay accounts of their condition with medical and state-sanctioned authority. For example, one patient said, when discussing taking a sick note in to work: *'It's easier to explain things to others if I can say it's this disc or that disc and not just back ache. Then they take me more seriously'* [patient 13]

The need to ritually re-enact the outward appearance of pain in order to persuade a sceptical doctor of the validity and severity of the illness claim can move a consultation some way from the ideal types of the stoical resilient patient and the sympathetic and caring doctor:

*'He's written fibromyalgia down as well on it [the note], ticked 'you may be fit for work taking account of the following advice', then he's ticked 'amended duties'. Now that's because when I went, he said, "Is it any better?" I said, "From how it was, yes, but it isn't right. It still keeps swelling up and everything else". As you're talking to him, it's almost as if he just doesn't want to know and doesn't want to listen...it's almost as if...if you're not committing suicide, he doesn't want to know. If I sat there in floods of tears and was screaming and shouting and everything else, perhaps he'd take more notice of me'* [patient 20]

This is likely to make the patient feel fraudulent, even if they are only enacting pain that *really is* present on other occasions. This account also exemplifies how being refused work absence led to patients feeling stigmatised as they perceived their accounts were trivialised. Whether or not patients wanted sick-listing, there was tension around the subjectivity of chronic pain, as patients thought that their own accounts should be an important part of the sick-listing process, but they did not see these accounts being fully recognised as central. When patients discussed their subjectivity it tended to be in the context of on-going conflict between the patient and doctor, as demonstrated by the quotation above, rather than seen as a helpful part of the consultation.

Doctors' and patients' accounts reveal that a lack of objective physiological evidence about the patient's illness and the doctor's lack of knowledge about the patient's workplace can generate uncertainty, mutual loss of trust, and conflict in the doctor-patient relationship, all of which can lead to inappropriate sick-listing and other negative outcomes. The recent policy initiatives to improve sick-listing attempt to remedy the knowledge deficit, but will they work? We put this question to patients and doctors and it is to their responses that we now turn.

### **Will the recent policy initiatives work?**

Doctors' views solely on the fit note have been discussed elsewhere (reference x). Here, we report doctors' and patients' views on the national education programme's tenet that work is good for our health and wellbeing, followed by patients' views on the fit note. We also explore the fit between policy initiatives and the practical task of improving sickness certification.

The national education programme was broadly welcomed in that all participants in both doctor and patient groups agreed with the concept that 'safe and accommodating' work is good for us (Waddell and Burton, 2006: p.ix). However, many doctors characterised patients' working environments as stressful, and discussed how they would be more inclined to sick-list people thus affected:

*'I mean most of the time I think work can be therapeutic - it's better to get back to work and be normal. But for some people, work is the issue, so then I write them a sick note'* [GP12]

Secondly, even when a doctor believed that a patient might be better off returning to work, they often found difficulty in arguing strongly for this course of action if the patient was wary or

unwilling, largely because they did not wish to appear uncaring or unsympathetic. One GP maintained: *'If people with chronic illnesses can be normal, it really helps; having a job is a normal thing to do...[but] I'm sappy soft'* [GP6]. Getting patients to follow a potentially beneficial course of action that they are opposed to can be a difficult task for doctors to accomplish. It goes against professional notions of concordance and patient-centred practice. However, some doctors were able to negotiate RTW even among resistant patients, not only by discussing the evidence base, but also by implementing tacit methods of persuasion and coaxing that they had developed as practitioners, such as tapered target setting.

Patients did not usually need to be persuaded of the benefits of work in abstraction, but rather in relation to their particular symptoms and circumstances. Thus, in principle, work was viewed positively, because *'people feel absolutely worthless, without work'* [patient 27] and many patients discussed its financial benefits. All the patients with jobs reported making great efforts to overcome challenging barriers (such as the fluctuating nature of chronic pain, dealt with by flexi-time where possible) because they valued their work financially and socially. Nonetheless, patients also talked of personal experiences which made work extremely difficult:

*'I'm currently managing to work full-time but at the complete expense of my social life. I'm always resting to recover from work and to ensure that I can work again the next day... just wanted to make it clear there's a price to pay for determination to carry on!'* [patient 19]

The social norm that work is good influenced this patient's choices, inhibiting her from adopting the sick role, which may be positive as she retained her job. However, she also appeared to be suffering socially and physically, and her identity as a capable worker and as someone able to

fully participate in life was spoiled Goffman (1968) even though her physical pathology was not impeding what she did at work.

We found some evidence that the way in which recent policy initiatives are being framed could generate negative responses that might impede RTW. Some patients were sceptical about the promotion of the benefits of work, viewing this as secondary to the political goal of reducing the social security benefits bill:

*'If I wasn't claiming any money from anybody, nobody would care. They wouldn't talk about the benefits of working and benefits to society - they wouldn't give a stuff about these things. It boils down to money. The rest of it is just kind of fancy rhetoric.'* [patient 1]

Some patients felt pressurised by what they viewed as harsh Government policies which posit sick-listed people as malingerers. If patients perceive RTW as a politically motivated drive to cut welfare costs, rather than a means of genuinely improving their lives, there is a danger that further absence from work will be constructed as a form of 'political resistance' to austerity measures and a means of preserving hard won benefits and entitlements. Other patients viewed the policy initiatives more positively, valuing the shift in emphasis from incapacity to capacity for work, and the possibility that the recommendations given in a fit note might encourage employers to provide more support for RTW:

*'My employers will see what I can do more clearly...I'm hopeful this might help me get more targeted support...I need some steps [to reach higher shelves] and then I can do more, so maybe my GP can say that, or maybe my boss can change my duties a bit'* [patient 28].

Although some patients hoped that the advice given in the fit note would make their employer *'sit up and take notice'* [patient 19], because of the primacy accorded to medical knowledge, others were more sceptical and did not perceive that the fit note would make any difference to them. Not because the advice contained in the fit note was necessarily wrong, but because the likelihood of the measures being implemented was due to the quality of the employer-employee relationship, rather than to the employer not knowing what should be done or requiring a push from the GP. For example patient 5 already had a good RTW plan agreed with his employer before the advent of the fit note and did not feel that the fit note would have added much to this: *'I don't think it would have made any difference, because they both [GP and employer] knew me well enough to know that I would go back as soon as I could.'* He felt that as he had a good relationship with his bosses and GP, and anyway wanted to return to work as soon as possible, the fit note made no difference to how his sick-listing was handled. Other patients, who perhaps had a poorer quality of employer-employee relationship, discussed how their employers would *'dance round'* [patient 14] the fit note, so that its recommendations would remain unimplemented. If the quality of the employer-employee relationship heavily influences the development and implementation of a RTW strategy, then the fit note alone is unlikely to be effective. It is not only knowledge deficit that accounts for prolonged sickness absence, but the quality of social relations between doctor, patient, employer and employee.

## **Discussion**

### **Beyond the knowledge deficit model and naïve rationalism**

There is compelling evidence that much sick-listing is unnecessary and that many patients signed off sick would do better if they remained in work. Successive UK governments,

keen to curb the costs of rising sickness certification rates, have asked why it is that doctors continue to sick-list on demand when the evidence base suggests they should do otherwise. The answers that policy makers have developed are largely based on the assumption that doctors and patients are simply unaware of the evidence that work is good for us and that most people can return to some form of work when they are less than 100 per cent fit, so long as their duties are appropriately amended and/or additional adaptations to the workplace are made. This assumption is based on the rational expectation that when doctors know what is best for patients, they do it, and that if patients are aware of this too, they will also comply. After Russell et al (2008) we would characterise this approach as 'naïve rationalism'.

Our findings challenge the adequacy of the knowledge deficit model. Our findings suggest that sickness certification is not, and arguably cannot be, based purely on firm evidence of what will be best for the patient. For non-specific or medically unexplained symptoms (which often accompany chronic pain), physiological evidence does not provide a compelling basis for diagnosis or management at the level of the individual patient. Instead, we found that doctors and patients are confronted by uncertainty, and decisions about capability and RTW are influenced by less rational factors, including: the patient's ability to enact pain convincingly, the doctor's capacity for empathy; competing notions of entitlement, obligation, sympathy and trust. These narratives exist prior to sick-listing consultations (Eccleston et al. (1997); Van Oorschot (2000) and our findings imply that they do not determine its outcome in a mechanistic or predictable way. Instead, we suggest that sick-listing depends upon a process of social negotiation, often comprising conflict and competing claims, as patient and doctor strive to establish the validity of the illness and what it means for the patient, specifically with regard to capability for work.

Sickness certification may be multi-factorial and unpredictable, but beneath this appearance of complexity we would argue that appropriate sickness certification is at least in part a function of the quality of the social relations that prevail between doctor and patient. From our findings, we suggest that where these relations are characterised by mutual lack of trust and empathy or by a structural conflict of interests, then developing and implementing a strategy for RTW is likely to be problematic, no matter what the evidence base might say about the likely benefits of doing so. The question is, are there any plausible policy interventions that might improve these social relations?

#### **Tacit skills and 'practice based evidence'**

A central finding of our research is that the sick-listing process for patients with chronic pain is dominated by uncertainty: uncertainty about the nature and severity of the illness, the patient's capability for work, the authenticity of the illness claim, and the likely outcome of returning to work. If so, then these uncertainties could give rise to mutual mistrust and conflict as both parties struggle to negotiate their own definition of the situation. The issuing of a sick note can often be a means of managing this conflict, going some way to restoring the patient's belief that the doctor recognises the validity of their illness claim, is sympathetic to their difficulties and is prepared to act on their wishes. However, even when a sick note is issued, either party may remain partially dissatisfied. The doctor may feel that the patient *could* and *should* have returned to work and that their decision to issue a sick note was unprofessional and not in the best interests of the patient. The patient may be left with a residual feeling of inauthenticity from the need to re-enact the symptoms of pain and a sense that the sick note has been issued grudgingly or against the doctor's better judgement.



Some of the doctors we interviewed said they had developed more effective responses to the uncertainties and tensions of the sick-listing consultation, for example, issuing sick notes, but reducing their duration, or actively trying to change the patient's expectations and beliefs about their illness and capability for work. These strategies often comprise tacit skills for establishing trust and empathy and coaxing the patient to consider the possibility of RTW. The latest iterations of work and health training programmes for GPs acknowledge the role played by these tacit skills and attempt to propagate good practice with regard to them. These training programmes have been successful not only at promoting GPs' awareness of the contribution work can make to health outcomes but at equipping them with negotiating strategies to manage challenging consultations (Cohen and Black, 2013). Our findings support this shift of emphasis. Gross et al. (2012) also show how complex it is to change beliefs and behaviour in relation to back pain, suggesting that multi-factorial approaches are best. We suggest that doctors' tacit knowledge and skills should be more extensively studied in relation to sick-listing, to produce a body of 'practice based evidence' that might move us further beyond the knowledge deficit model towards the model of doctor-patient negotiation and persuasion.

## **Conclusion**

The desire of successive UK governments to reduce sickness certification and enable more patients with chronic pain to remain in work is a laudable one, that may improve the health and well-being of patients, reduce costs to employers and the tax-payer, and even effect greater social justice. However, the likely effectiveness of current policy interventions may be limited by the adoption of a knowledge deficit perspective which assumes that inappropriate sick-listing is largely a function of ignorance of the evidence base relating to the benefits of remaining at

work. Sorting those who should remain at work from those who should not is a far more complex process than it may appear. Evidence from practice has a role to play, and our findings suggest that there are many psycho-social and economic factors impacting on the negotiation of sick-listing. The most recent policy and training materials are beginning to recognise this, emphasising the need to equip GPs with the rhetorical and persuasive skills, although they could go further. Future research could focus on the efficacy of these skills in promoting RTW and assessing the extent to which they can be codified and shared through training and professional development.

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None.

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