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ORIGINAL ARTICLE

Considerations made by the general practitioner when dealing with sick-listing of patients suffering from subjective and composite health complaints

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Abstract

Objectives. To explore GPs' considerations in decision-making regarding sick-listing of patients suffering from SHC. **Design.** Qualitative analysis of data from nine focus-group interviews. **Setting.** Three cities in different regions of Norway. **Participants.** A total of 48 GPs (31 men, 17 women; aged 32–65) participated. The GPs were recruited when invited to a course dealing with diagnostic practice and assessment of sickness certificates related to patients with composite SHCs. **Results.** Decisions on sick-listing patients with SHCs were regarded as a very challenging task. Trust in the patient's own story and self-judgement was deemed crucial, but many GPs missed hard evidence of illness and loss of function. Several factors that might influence decision-making were identified: the patients' ability to present their story to evoke sympathy, the GP's prior knowledge of the patient, and the GPs' own experience as a patient and their tendency to avoid conflicts. The approach to the task of sick-listing differed from patient-led cooperation to resistant confrontation. **Conclusion and implications.** Issuing sickness certification in patients with composite health complaints is considered challenging and burdensome. It is seen as mainly patient-driven, and the decisions vary according to GPs' attitudes, beliefs, and personalities. Guiding the GPs to a more focused awareness of the decision process should be considered.

Key Words: Education, family practice, primary health care, sickness certification, sick-listing, subjective health complaints, work incapacity

Subjective health complaints (SHCs) account for a great proportion of the encounters in general practice [1,2], and include conditions like musculoskeletal pain, tiredness, fibromyalgia, gastrointestinal complaints, depression, and anxiety [3–9]. SHCs are characterized by a plurality of symptoms and often a lack of objective findings or specific pathology to fully explain the complaints [7,10–12]. Lack of objective findings makes assessment difficult and leaves room for great variation in assessment of these patients, including the decision on whether to grant sick leave.

A sickness certificate may be granted in Norway if a reduction in work capacity is due to disease or injury [13,14]. Some 79% of the total number of sickness certificates are issued by general practitioners

(GPs) [13]. This assessment is often difficult and complex, and many physicians are uncomfortable carrying out these duties [15], being caught in the crossfire between the patients' demands for sick-listing and society's pressure to act more restrictively [15,16]. Knorring and her collaborators [17] report that many GPs expressed fatigue, despair, and lack of pride in their work concerning sick-listing. GPs find it particularly challenging to deal with issues of sick-listing when the decision is solely based on the patient's own report of complaints [17,18].

The GP's age, sex, and whether the GP is a specialist or not, and also how the patients present their problem are factors found to influence decisions regarding sick-listing [19,20,22]. Norrmen et al. [21]

Although we have some knowledge concerning GPs' practices on sick-listing in general, less is known about how GPs make their assessments regarding sick-listing in the more complex cases of patients with subjective health complaints (SHCs).

- Decisions on sick-listing patients with SHCs are considered by GPs as a demanding and challenging task and are seen as mainly patient-driven.
- Handling of the sick leave decisions varies greatly, according to GPs' attitudes, beliefs, and personalities.
- Focused awareness of the decision process through more specific education and training among students and GPs should be considered.

found that the strongest predictors for granting sickness certification were agreement between patients' and GPs' assessment of reduced work capacity. When the patient's complaints were judged to be non-somatic, the risk of being sick-listed also increased. However, there is scarce knowledge concerning how physicians actually make their assessment, especially in the more complex cases. The aim of this study was to explore what considerations are made by GPs when they decide whether patients with SHCs are eligible for sick-listing.

Material and methods

Data were drawn from focus-group interviews with GPs attending a course dealing with diagnostic practice and assessment of sickness certificates in patients with composite health complaints. In this course, the GPs were shown videotapes of consultations with patients where decisions on sick leave were to be considered. The videotapes also provided background for a broader discussion concerning sick-listing of patients with SHCs.

A total of 48 GPs, 17 women and 31 men, aged 32–65, 15 being from countries other than Norway, participated in focus-group discussions. Their work experience in family medicine varied from one to 34 years. Most of the GPs worked in an urban setting. Nine group sessions (70–90 minutes) with 4–6 participants in each group were conducted. Many of the foreign GPs had a large number of individuals from their native countries as patients. Three groups consisted of men, one of women, while the rest were of mixed gender. Three of the authors were moderators (SN, LM, EW). An observer took notes in

each group evaluating atmosphere and interaction. A semi-structured interview guide with open questions regarding sick-listing decisions was used. The questions were related to the videotapes, but also to specific examples from the GP's own practice. The interviews were audiotape recorded and transcribed verbatim. The study was approved by the Regional Committee for Medical Ethics and the Norwegian Data Inspectorate.

Analysis

Data were analysed by systematic text condensation inspired by Giorgi's phenomenological analysis through a four-step analysis procedure: getting a total impression, identifying meaning units, abstracting contents of individual meaning units, and summarizing their importance [23,24]. The quotations are identified by numbers corresponding to the participants.

Results

The factors influencing the decision regarding sick-listing may be sorted under the following categories.

The dilemma of no objective signs

The lack of objective signs of illness in these patients was mentioned by the participants as a fundamental challenge, often evoking negative feelings and doubts. One expressed uncertainty as to whether the patient really has a disease that merits a sickness certificate. Another described how she felt more comfortable when she had some real evidence to justify the decision of granting a sickness certificate to the insurance authorities. A young female GP expressed it thus:

I become uncertain when I have to build my decisions on diffuse, ever changing symptoms, varying from week to week. (7)

An objective finding, however subtle, which might support the patient's story would make the decision easier for some GPs, but disagreement appeared on whether a particular sign could be taken as "proof" of disease.

Trusting the patient

When lacking proof, trust becomes paramount, several informants stated. They pointed to their basic trust in the patient as one of the main foundations when considering issuing a sickness certificate. Several regarded the patient as the best judge of his/her

need for sick-listing, and chose to put great emphasis on this self-evaluation. A female participant in her forties said that as she had become a more experienced GP she went from being sceptical and doubtful to more understanding, and now might readily grant a sickness certificate even for prolonged periods as a result of increased empathy and ability to see the patient's situation. A male GP of 30 years' experience put it this way:

I need to have a "naive" approach to the patient, his story and his judgement of his own lack of work ability; I can't live every day with the notion that people are lying to me. (9)

But views on this differed, as some had experienced dishonesty from patients, and as a result had become suspicious. One participant demanded that the patient must be able to provide some kind of proof of his incapacity:

If I suspect that a patient is about to trick me, I try to prove this by examining him several times, as it would be difficult to reproduce simulation. (45)

Prior knowledge

Prior knowledge of the patient was also deemed important by several. Having known a patient for many years would make it easier to make a confident judgement about the patient, whereas younger participants, especially when they had recently taken over a patient from a colleague, expressed greater doubts about assessment of sick-listing. Insight into the patient's general life situation and working conditions was also mentioned as an important factor. Another said she might even insist that the patient be sick-listed if she knew him well enough, and considered that the patient refused to see what was for his own good. No previous history of sick-listing made the decision easier. One GP explained:

One is able to compare the patient's level of functioning with his usual capacity, and hence more easily identify a loss of working capacity, and be more comfortable about the decision to sick-list. (20)

Purpose of sickness certificate

Another view expressed was that in order to grant a sickness certificate it must serve a specific purpose: having a disease that requires rest in order to heal, or the disease making the patient unable to carry out his/her working tasks. The GPs saw some of

their patients as more vulnerable than others, and considered that a short period of sick-listing would provide a necessary "time-out" from the often overwhelming stress experienced at work. The alternative might be permanent disability. One male GP of 60 described his reasoning this way:

I ask myself: What is the purpose of staying away from work in this case? Is it to avoid something unpleasant, or is it part of a treatment plan? Is it to escape from a conflict with a colleague or will he actually become more ill if he continues to work? This is a jumble that I need to straighten out. (17)

The doctor's inner feelings

Feelings within the GPs themselves that could influence decisions concerning sick-listing were also identified. A female participant described how she could be moved by a sad life story, and be more likely to grant more extensive sick leave. Other situations that might generate sympathy were mentioned: seeing the patient as a hard-working, earnest person trying to mend his life, or expressing a strong will to recover and return to work. Some participants also commented on how they could become influenced by the expressive style of their patients. A demanding, condescending patient might inflict negative feelings in a GP, while a more humble approach could evoke sympathy. One female GP mentioned that her own experience as a patient would influence her decision on sick-listing in a similar case.

Some patients' demanding attitude towards sick-listing would evoke negative feelings in the GPs, and they described the question of sick-listing as sometimes a regular battle. Some admitted that by nature they were likely to avoid conflicts, and therefore were reluctant to get into fights with patients pressing hard for extended sick leave. One voiced feelings of self-regret for not being able to do so, while others described the frustration and anger of being hostage to a system where the patient is the obvious winner, even if the GP did try to put up a fight. Some GPs, on the other hand, expressed confidence when they found it appropriate to actively confront the patient. They expressed no worries at losing the patient or feeling the patient's resentment. A female GP of 45 put it this way:

After a long period of sick leave I told him: Who should take responsibility for the fact that you don't like your job? The system has been carrying you for eight months, it's about time you make an effort yourself, or decide to find a new job. He reluctantly went back to work, probably admitting to himself that I wasn't totally wrong. (39)

Some also described how their own present spirit and feeling of well-being was decisive when dealing with difficult questions about sick-listing. They were more likely to question or refuse a request they saw as unjust when they themselves felt strong and fit. On the other hand, when pressed for time, or when feeling tired, they more easily gave in. One young female GP phrased it like this:

You have to pick your fights carefully. You can't fight with 20 patients a day. When I am due to pick up my son in kindergarten in 20 minutes, I am not likely to try to push a reluctant patient back to work. (6)

Discussion

This study demonstrated that the GPs find sick-listing patients with SHCs a very challenging task. Lacking hard evidence of illness and loss of function, the GPs put trust in the patient's own story and self-judgement. Factors influencing decision-making regarding sickness certification included the patient's ability to evoke sympathy, extensive prior knowledge of the patient, and also properties within the GPs: their own experience as a patient and tendency to avoid conflicts. The approach to the sick-listing task differed through a broad range from patient-led cooperation to resistant confrontation. Even if composite health complaints were the starting point for the study, many of these findings regard sick-listing in general.

Invitation to participate was sent to all Norwegian GPs and the interviews were conducted in three large cities in different parts of the country. This might have favoured GPs working in urban areas, thus giving relatively low rural representation. Also, since the focus groups were part of an educational programme, the GPs might have felt an obligation to participate. We had a large number of participants, and the interviewing went on until no further information was obtained. We therefore consider the material to be saturated and to present a broad range of views on this topic. Viewing videos of clinical examples prior to the focus groups might have stimulated awareness and focused the discussion. Also, many of the GPs from other countries described a patient population dominated by immigrants from their native country, thus adding diversity to the information obtained.

Considerations concerning sick-listing of patients with SHCs seem to be subject to great variation among GPs. While some seemed to readily accept their patients' complaints, others remained sceptical and doubtful when approached by such patients. The conflicting attitudes may be grounded in different

views of disease and medicine in general. These differences may be based on personal beliefs and personalities, and on the medical traditions of the GPs' education and training [25]. GPs who are embedded in an understanding of disease as an objective entity may, in the meeting with these patients, find themselves in a strange world for which they are ill prepared [17,26]. It is tempting to suggest that GPs who apply a more bio-psychosocial view of medicine will be more ready to sick-list these patients, and do so without regrets or doubts. Also, as these patients might be regarded as difficult to treat, a sickness certificate could be seen as the most obvious solution to relieve some of the patient's suffering. It is hoped that a more profound understanding and improved treatment of this patient group in the future will provide the doctor with a better rationale when deciding whether sick-listing is justified.

Some of our informants stated that they were reluctant to grant sick-listing when lacking objective proof of disability. Hence, one could surmise that patients with somatic diseases would be more likely to receive a sickness certificate. Interestingly, a Swedish study [21] made the opposite observation: lack of somatic findings increased the likelihood of being sick-listed. One explanation may be that GPs would in principle prefer solid proof of disease before sick-listing, but find it hard to follow this through in real life.

Trust and knowledge were mentioned as key factors on which the GPs based their decision. A lasting and close relationship will build trust, and will also increase the physician's knowledge of the patient, making a sickness certificate in these difficult cases easier to grant. The GP listing system in Norway that was introduced in 2001, where the doctor became responsible for a specific list of individuals, has probably contributed to a stronger relationship between GPs and patients in general, which may add to an increase in sick-listing. On the other hand, within this system a patient is granted the right to change GP up to twice a year. The informants in our study had experienced that a patient might leave for another GP should a conflict concerning sick-listing occur. This "shopping around" for sickness certificates is also described in the UK, where a similar primary health care scheme is in use [29]. Thus, the listing system might facilitate an increase in the volume of sickness certificates through different mechanisms.

Although a reduction in working ability due to illness is a prerequisite for sick-listing [14], this consideration was not strongly emphasized by the GPs. This could imply that the physician considers this task impossible to evaluate in these complex cases, or simply does not focus much on this aspect, paying more attention to subjective symptoms and

expressions of suffering. There is also reason to believe that GPs have little training in evaluation of work capacity [30]. Sick-listing is described, for the most part, as a patient-led process, where the patient gets what he/she wants [29], and there is evidence that the patients' opinion rather than the GPs' is decisive for the outcome of sickness certification [28,29]. The shift towards a patient-centred approach in recent years has probably added to this effect, as decisions regarding treatment and other aspects of the consultation are reached in close cooperation with the patient. This attitude towards the patient is strongly emphasized in contemporary medical education, while disregarding the patient's views is unheard of. A young doctor is thus left with few tools in dealing with complex sick-listing decisions.

Both the GPs' deeper understanding of and attitude towards their SHC patients and their personal style and personality traits seem to play a role in these considerations, and the GPs seemed to be aware of their own feelings, personalities, and prior experiences as influencing their decision-making. At the same time, it has been found that GPs acknowledge lack of competence and ask for more extensive education and training in these matters [15]. Both as students and in postgraduate training, they will need guiding and counselling: in dealing with SHCs in general, in assessments of working ability, and finally, but not least, in how to deal with the emotions that arise in both the patient and the GP when disagreement occurs. One possible way to solve this dilemma is to reduce the GP's role in sickness certification and pass this responsibility to other agencies or to the patients themselves, but this view has not been given great support in the ongoing assessment of sick-listing policies in Norway.

Conclusion and implication

Assessment of work incapacity in patients with SHCs is considered by GPs as a demanding and troublesome enterprise and varies according to the GPs' attitudes, beliefs, and personalities, and to a large degree the decision process is seen to be patient-driven. Guiding the GPs to a more focused awareness in balancing conflicting views regarding sick-listing through specific education and training is essential. A deeper understanding of these complex cases might in the future also lead to a more rational selection of those who will really benefit from a sickness certificate. This progress will, it is hoped, empower the GP and reduce arbitrary and possibly unequal assessment of sick-listing, thereby improving equality of the patients' right to sickness benefits.

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