



ORIGINAL ARTICLE

GPs' negotiation strategies regarding sick leave for subjective health complaints

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Abstract

Objectives. To explore general practitioners' (GPs') specific negotiation strategies regarding sick-leave issues with patients suffering from subjective health complaints. **Design.** Focus-group study. **Setting.** Nine focus-group interviews in three cities in different regions of Norway. **Participants.** 48 GPs (31 men, 17 women; age 32–65), participating in a course dealing with diagnostic practice and assessment of sickness certificates related to patients with subjective health complaints. **Results.** The GPs identified some specific strategies that they claimed to apply when dealing with the question of sick leave for patients with subjective health complaints. The first step would be to build an alliance with the patient by complying with the wish for sick leave, and at the same time searching for information to acquire the patient's perspective. This position would become the basis for the main goal: motivating the patient for a rapid return to work by pointing out the positive effects of staying at work, making legal and moral arguments, and warning against long-term sick leave. Additional solutions might also be applied, such as involving other stakeholders in this process to provide alternatives to sick leave. **Conclusions and implications.** GPs seem to have a conscious approach to negotiations of sickness certification, as they report applying specific strategies to limit the duration of sick leave due to subjective health complaints. This give-and-take way of handling sick-leave negotiations has been suggested by others to enhance return to work, and should be further encouraged. However, specific effectiveness of this strategy is yet to be proven, and further investigation into the actual dealings between doctor and patients in these complex encounters is needed.

Key Words: Family practice, focus groups, general practice, health communication, negotiating, Norway, return to work, sick leave

Introduction

The sick-leave rate in Norway is higher than elsewhere in OECD countries [1]. Musculoskeletal pain, tiredness, anxiety, or gastrointestinal complaints, often referred to as subjective health complaints (SHC) [2], are among the main reasons why people ask for sickness certification [3]. The social and economic costs related to absence from work have concerned the authorities, and several initiatives have been introduced to control the situation. In Norway, as in a number of other Western countries, doctors have been given the assignment of providing medical premises for sickness benefits, and there is an

increased focus on the doctor's role in sickness certification internationally. In the public debate, general practitioners (GPs) have been accused of taking a passive and indifferent attitude towards issuing sickness certificates. GPs admittedly have reported that they find decisions regarding sickness certification, especially in patients with SHC, challenging and frustrating [4–6]. Lack of competence in assessing work ability has been expressed, particularly in patients with psychiatric conditions. Thus, sick-leave negotiations may be avoided due to time constraints [7]. GPs miss objective evidence of illness and lack of work ability in these cases, and must rely on the

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Decisions concerning sick leave for patients with subjective health complaints (SHC) are among GPs' most demanding tasks.

- GPs are aware of and apply specific strategies when negotiating sick-leave issues with patients with SHC, seeking to limit the sick-leave duration.
- Building an alliance by trying to understand the patient's situation and seeking deeper knowledge of the patient's request was considered to be a necessary starting point in these negotiations.
- Focusing on early return to work by emphasizing the benefits of work, bringing up legal issues, and cooperation with the other stakeholders were identified as the main elements in further negotiations.

patient's own report when deciding whether he/she is eligible for sickness certification [8]. Prior knowledge of the patient, the patient's ability to generate sympathy, and the doctor's own experience as a patient are among factors that doctors report as having an influence on their decisions [4].

From the discipline of public policy, Michael Lipsky describes how public servants, from teachers and police officers to social workers and GPs, interact directly with the public, and in doing so represent the frontlines of government policy [9]. His concept *street level bureaucracy* provides a useful perspective to understand the impact of the social structure on what is going on between doctor and patient.

Coming from different clinical professions, the authors shared an interest in the specific process and discussions underlying a sickness certificate decision. More specific insight into GPs' experiences can provide a base for initiatives to improve the standard of sick-leave assessment. Often, the issue of sick leave in these cases leads to discussions between patient and doctor. There is, however, sparse knowledge of how the actual discussion between doctor and patient on this topic is taking place. We therefore wanted to explore GPs' specific strategies for negotiation regarding sick-leave issues with patients suffering from SHC.

Design, material, and methods

We conducted a focus-group study with Norwegian GPs attending a workshop concerning sickness certification. A total of 48 GPs (17 women and 31 men, aged 32–65) participated once in nine focus-group

sessions (70–90 minutes) with 4–6 participants in each group. This workshop (duration two days) was a single event, arranged by Uni Research Health, as part of a research project. Recruitment was made through advertisement in the journal of the Norwegian Medical Association. The participants' general practice experience varied from one to 34 years. Most of the GPs worked in an urban setting. About 30% of the GPs were from countries other than Norway, including Denmark, Sweden, Germany, Pakistan, Iraq, and Ethiopia, many of them having a large number of individuals from their native countries as patients. All the participants participated in the focus groups. Three of the groups consisted of men, one of women, while the rest were of mixed gender. In the workshop, participants first assessed all nine videotaped consultations of patients suffering from SHC [10]. They were then individually requested to decide whether sick leave was appropriate in each case [4]. In the video consultations the patients were played by different actors, but the content was transcriptions of real consultations. Focus-group discussions were carried out prior to subsequent lectures, thus preventing content from lectures being echoed back in the group discussions. Three of the authors acted as group moderators (ELW, SN, LHM), and one co-moderator in each group took field notes. Open-ended questions regarding sick leave were related to the videotapes. The discussions evolved around the decision on whether or not to issue sickness certificates, and how they would handle the negotiation with the patient in this regard, especially when disagreement occurred. Specific examples from the GPs' own practices were also brought into the discussions. The study was approved by the Regional Committee for Medical Ethics (08/12758) and the Norwegian Data Inspectorate (09/20381).

Analysis

Data were analysed by Systematic Text Condensation, a thematic, cross-case strategy suited for exploratory analysis [11]. This procedure consists of a four-step analysis: (i) getting a total impression by reading the whole text to identify preliminary themes, (ii) identifying meaning units concerning GPs' different strategies when negotiating sick leave for patients with SHC, establishing code groups, and sorting the meaning units correspondingly, (iii) abstracting condensates from each code group and its subgroups, (iv) re-conceptualizing the condensates by creating synthesized descriptions of GPs' strategies. Analysis was supported by Lipsky's theories regarding street-level bureaucracy, focusing on the GPs' potential trade-offs between the concerns of the patient and the public responsibility [9].

Results

The GPs reported that they used specific strategies for negotiation of sickness certification with patients with SHC. The first step would be to build an alliance with the patient by complying with the wish for sick leave, and at the same time searching for information to acquire the patient's perspective. This position would become the basis for the main goal: motivating the patient for a rapid return to work, by pointing out the positive effects of staying in work, making legal and moral arguments, and warning against long-term sick leave. Alternative solutions might also be applied, such as involving other stakeholders in the sick-leave process to provide alternatives to prolonged sickness certification. These findings will be elaborated below.

Building an alliance – acquiring the patient's perspectives

There was a general agreement among participants that long-term sick leave for many of the patients with SHC would be counter-productive, with a considerable risk of turning into permanent disability. Nevertheless, many voiced the importance of initially meeting the patient's request for sickness certification in a positive way, seeking to build an alliance. They described in different ways how this alliance could be established by trying to understand the situation from the patient's position, and "walking along" with the patient – a starting point for later negotiations.

An element of alliance building would sometimes be to agree to the first request for sick leave. Since the patient's point of view in the first consultation might be a clear request for a sickness certificate, initial rapport with the patient was considered a prerequisite, before discussing further details. Some GPs also described how, at this step, they explored more deeply the patient's complaints and expressed need for a sickness certificate. It was pointed out in different ways that the initial complaint to justify sick leave could be misleading, with physical complaints often disguising more severe personal or psychological problems. The insight gained by this strategy would make it possible to address the full range of problems, sometimes leading to more accurate management of the situation. An experienced male doctor of 60 working in a rural setting in Eastern Norway gave this advice:

"When I deal with long-term sick leave for conditions I don't quite understand, I always talk to the patient about his work, his marriage, his children and his financial situation. A lot of trouble lies hidden here".

Rapid return to work is still the main goal

Several of the participants claimed that although rapid return to work was their main goal on behalf of the patient right from the start, they advocated the principle of not pushing this point initially. Some participants warned against giving too much resistance in the first consultation, because this might enhance the possibility that the patient moved to another doctor's list. Others advocated this confrontation style as a way to get rid of a difficult patient. Some described how they would make an early follow-up appointment after a limited initial period of sickness certification, starting to negotiate return to work as soon as possible. This could be obtained by changing to part-time sick leave, or, on some occasions, starting out with this option from the beginning. Some of the GPs emphasized how these strategies of alliance and rapid return to work might be closely linked, as a more or less orchestrated chain of events, where the doctor moved along with the patient from one stage to the next, towards the final goal of terminating the sick leave at an early stage. A female doctor aged 35 years, working in an affluent part of a major city, put it this way:

"I acknowledge their need for a sick-note initially, and bring in the "but" in the next consultation".

When the GPs intended to motivate their patients for early return to work, several approaches were recommended, using rewards as well as forewarnings. Pointing to the positive effects of work participation on the patient's well-being, they would seek to ease the patient's fear of the potential dangers of re-entering work. At the same time they advocated the moral obligations of participating in society, while warning the patient of the possible drawbacks of staying out of work for a prolonged period such as tardy recovery, economic loss, or falling out of work permanently. A male doctor of 45 explained:

I try to point to the rewards of being able to stay in work, and that work can in fact empower you and bring you better health, while trying not to be too moralistic about it.

Some GPs said they would also bring up their responsibility towards the authorities and the social laws and regulations when arguing against long-term certified sick leave. They might for instance explain their inability to comply with the patient's immediate wishes by pointing to their own obligation to follow the rules. One experienced male doctor said that he would press for termination of sickness certification after eight weeks, pointing to the stricter conditions that Norwegian law applies to prolonged cases. He

also admitted that he sometimes exaggerated these rules to bring the patient back to work:

"I might say that I can't write a sick note past the employer's payment period [16 days] or the eight weeks. I think it's a great relief to have these excuses."

Alternative solutions may be available – other stakeholders might provide options

Some of the participants described how they would also try to point to alternative solutions to sick leave, such as a temporary change to different working tasks, a change to another job, or by encouraging the patient to reorganize family life to ease the perceived domestic stress factors, rather than blaming the job and solving the problem with a sickness certificate.

Furthermore, several of the participants pointed to the possibilities of cooperation with other agencies or partners to find other alternatives to sick leave. They were aware of their legal duty to involve the patient's employer in such cases, but admitted that they did not apply this opportunity as often as they should. They would also sometimes inform the Norwegian Labor and Welfare Administration (NAV) when feeling uncomfortable about long-term sickness certification, but complained about not receiving due response from the welfare system to such signals. A female GP of 45 related this experience:

"If I sense that this might become a questionable case of prolonged sick leave, I will notify the social security agency right from the start, so they will have the opportunity to intervene at an early stage. But nothing ever happens; not in months. And that's when I kind of give up. What am I supposed to do now?"

Discussion

In our study, the doctors did not seem to act as careless providers of sickness certificates, but in fact expressed awareness by reporting specific strategies with the aim of seeking to limit the duration of sickness absence for patients with SHC. The overall strategy was described as a stepwise process, consisting of alliance-building and mutual understanding, then actively focusing on early return to work, supported by involvement from other stakeholders.

Methodological considerations

The participants in our study were recruited through a course for GPs dealing with sick leave and related topics. They might have had a certain interest in these issues, implying a potentially more conscious and reflective attitude towards the challenges of

sickness certification than other GPs. On the other hand, doctors seeking education in a particular field may be more aware of their shortcomings than their colleagues, and may provide for a more self-reflective discussion. These two factors might balance each other. The fact that the course was free of charge probably made it attractive to a wide group of GPs. We therefore conclude that our sample held satisfactory external validity, and that these results can be transferred to a broad range of GPs working within similar rules and procedures for sick leave [12]. In the focus-group discussions, participants described their strategies by talking about what they usually did, or would like to do, in specific situations. We do not know whether this takes place in real life. Although the strategies presented by participants were often substantiated by specific examples and experiences, internal validity will be jeopardized if we confuse these descriptions with what actually takes place. An observational study with data drawn from videotapes of real consultations would be needed for such a purpose, and our findings must be interpreted with due caution [13].

We consider the clinical experience among the authors as a strength when it came to guiding the discussion onto clinically relevant topics, and to recognizing and appreciating the GPs' work situation and points of reference. On the other hand, this position could also implicate a sympathetic relationship to the informants and their work situation, and thereby prevent a sufficiently reflective view.

Although this study dealt with patients with SHC, the focus-group discussions sometimes took in a broader view, and discussed dilemmas concerning complex long-lasting sickness-certification cases in general. Our findings therefore also shed some light on a broader range of situations where sickness certificates are under consideration. Some aspects of the findings, like balancing medical judgement when it is opposed by the patient's demands, may also be transferred to other situations of negotiations over controversial issues in general practice, such as prescription of antibiotics [14,15].

What is known from before – what does this study add?

In this study GPs demonstrate a wide range of strategies they use when considering sickness certification for patients with SHC. This is somewhat opposed to popular assumptions of GPs as passive servants of a sick-note [16–18]. Sickness certification in SHC cases in general seems to be patient initiated [4,19,20], and the GPs in this study demonstrated great concern about the risk of marginalization following long-term sick leave [21].

We have previously published research suggesting that GPs do indeed take into account a number of considerations when assessing the need for sick leave [4]. This paper further reveals how doctors negotiating sick leave seek to find a balance between compassion and flexibility on one side, and impartiality and strict rule-application on the other, facing the dialectic dilemma of all public services. Lipsky's theory fits well with some of the dilemmas of issuing sickness certificates [9]. However, unlike most other public services, there is no budget to be accounted for by the medical street-level bureaucrat in Norway when it comes to sickness certification. Consequently there are no financial limits to consider and our findings may reflect this situation, as flatly refusing sickness leave when judging it to be questionable was not mentioned by our participants. This is in accordance with findings by Swartling et al. [22]. GPs' budget responsibility has an impact in other areas, e.g. drug prescription, and one could hypothesize as to whether freedom from this responsibility may partially explain why the gate-keeping part of the equation is played down in sickness certification discussions [23].

Balancing society's demand for gate keeping with the need to be supportive and keep on good terms with the patient is a recurrent issue when discussing GPs' roles in sick leave [5,7,24]. In a study by Hiscock et al. [16], doctors reported having adopted a "give-and take" strategy, and compromise has been found to be a key element in order to avoid conflicts. In our study, the GPs' descriptions of how their seeking an alliance and reaching an agreement with the patient before turning their attention towards work elaborates on this strategy. The elements of a patient-centred approach in communication are clearly recognizable, and demonstrate a shift from GPs' more paternalistic attitude of the past [25–27]. This way of communicating may enhance the return to work. Lynoe et al. [27] found for example that positive encounters with health care providers combined with feeling respected significantly facilitated patients' self-estimated ability to return to work, while negative encounters combined with feeling wronged significantly impaired it.

Patients with SHC on long-term sickness absence have further elaborated on how they wish to be encountered by their doctors. They express the need for sufficient time, sympathy, and confidence from their GPs in the process of trying to regain work ability, while a perceived insensitive attitude and pushing too hard towards work might impair their health [21]. Carefully balancing the concerns of the patient and the public responsibility during negotiations is therefore paramount, and attention to the patient's feelings and opinions must be respected.

The GPs in our study expressed a strong awareness of this challenge.

A potential conflict of interest may exist between GPs on one side, and occupational health services and employers on the other, where GPs are seen as primarily concerned with diagnosis and effective treatment, ignoring return to work and quality of life in general [28–30]. GPs trained in occupational health felt that when they negotiated sickness certification their training helped them to challenge beliefs about work absence being beneficial to patients experiencing ill health [31]. After training, they felt better equipped to consider patients' work ability, and issued fewer certificates as a result of this. Our study may balance these findings, as our participants claimed to argue strongly for the benefit of work in negotiations with their patients, and to seek a rapid return to work before all symptoms are relieved. This finding indicates an emerging mutual understanding between GPs and other stakeholders that may prove beneficial in reducing long-term sickness absence.

Functional assessment has been proposed as a tool to adjust the duration of sickness certification periods [32]. Doctors' insufficient knowledge of patients' work demands and lack of contact with the employer may comprise barriers to this approach. Lipsky [9] also mentions the challenges when street-level bureaucrats have to make a large number of decisions with limited time and information available. None of the participants in our study mentioned assessment of work ability as a main element when deciding whether sick leave was appropriate. Since lack of work ability is an absolute prerequisite for receiving compensation for sickness according to Norwegian social law, as elsewhere, one would expect the doctors to pay some attention to this issue in their discussion with the patient [33]. When this seems not to be the case, it may reflect that the doctors' focus in patients with SHC is directed more towards the patient's subjective description of complaints, suffering, and function, as the exact work ability can be difficult to decide or define when dealing with SHC. However, increased attention to this topic when negotiating sickness certification may facilitate return to work.

Long-term sickness absence is the shared responsibility of four principal stakeholders: the doctor, the employer, the social security officer, and the patient him/herself, as pointed out by Werner [34] and Kiessling & Arreløv [7]. Our participants' strategies of turning to legal arguments and hiding behind other public agencies illustrate their reluctance to stand alone, and their need for support and collaboration with the other stakeholders. Closer follow-up of doctors by social security officers has been suggested to improve sensible decision-making in long-term sick-

ness absence [35]. However, although the GPs in our study were aware of possible options for cooperation and support, they did not take full advantage of these. Fear of breaching confidentiality on the patient's behalf might be a barrier to this approach. A lack of collaboration experienced with social welfare agencies and employers, especially regarding practical difficulties in reaching them, may add to the barriers to cooperation, as pointed out by Swartling et al. [55].

Implications

The GPs participating in this study demonstrated a keen awareness of specific strategies to limit prolonged sick leave for SHC. Still, it is uncertain whether this give-and-take approach to sick-leave negotiations may enhance return to work, as the effects of such efforts are difficult to demonstrate. What is actually taking place behind closed doors in the consultation room when these complex situations are discussed is still unclear. More knowledge is needed regarding complex sick-leave encounters, especially when additional factors beyond the medical ones motivate the patient's wish for sickness certification.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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