

Primary care

Sickness certification system in the United Kingdom: qualitative study of views of general practitioners in Scotland

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Abstract

Objectives To explore how general practitioners operate the sickness certification system, their views on the system, and suggestions for change.

Design Qualitative focus group study consisting of 11 focus groups with 67 participants.

Setting General practitioners in practices in Glasgow, Tayside, and Highland regions, Scotland.

Sample Purposive sample of general practitioners, with further theoretical sampling of key informant general practitioners to examine emerging themes.

Results General practitioners believed that the sickness certification system failed to address complex, chronic, or doubtful cases. They appeared to develop various operational strategies for its implementation. There seemed to be important deliberate misuse of the system by general practitioners, possibly related to conflicts about roles and incongruities in the system. The doctor-patient relationship was perceived to conflict with the current role of general practitioners in sickness certification. When making decisions about certification, the general practitioners considered a wide variety of factors. They experienced contradictory demands from other system stakeholders and felt blamed for failing to make impossible reconciliations. They clearly identified the difficulties of operating the system when there was no continuity of patient care. Many wished either to relinquish their gatekeeper role or to continue only with major changes.

Conclusions Policy makers need to recognise and accommodate the range and complexity of factors that influence the behaviour of general practitioners operating as gatekeepers to the sickness certification system before making changes. Such changes are otherwise unlikely to result in improvement. Models other than the primary care gatekeeper model should be considered.

Introduction

In the United Kingdom, the provision of sickness certificates is part of general practitioners' contractual service. Guidance is provided from the Department of Work and Pensions, a branch of the Department of Social Security.¹ Statistics for 2002 show that of 4.9


million people of working age claiming key benefits, 3.0 million were claiming sickness benefits.² Only a proportion may be regarded truly as unfit for work because of medical reasons.³ General practitioners have potentially conflicting roles as patient advocate and gatekeeper for the Department of Work and Pensions.⁴ Objective clinical findings are present in only a few instances of sickness certification.^{5,6} Sick leave seems to be negotiated between doctor and patient, but general practitioners may feel coerced into writing certificates.^{4,7} Operation of the system seems to be inconsistent, with variation both between and among doctors.⁸ Both doctors and patients are dissatisfied with the current arrangement.⁹


Other developed countries also experience problems with sickness absence and certification procedures.¹⁰ We aimed to qualitatively explore how general practitioners operate the sickness certification system, their views on the system, and suggestions for change.

Methods

Our study population consisted of general practitioners working in Glasgow, Tayside, and Highland regions in Scotland to ensure that perspectives were obtained from a variety of settings: inner city, suburban, small town, rural and remote. Recruitment strategies and the topic guide were informed by two preliminary focus group sessions. In total, 11 one hour sessions (67 participants), were conducted in primary care settings (group size between four and eight participants).

Initially we used purposive sampling to include general practitioners with a range of characteristics, experience, and views. The first eight focus groups consisted of principals, with a few assistants and general practitioners in training. Theoretical sampling was used in three final groups to investigate emergent themes. A group of registrars and a group of locum general practitioners were recruited specifically to

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explore themes raised by the earlier general practitioner principal groups. Participants in the preliminary groups indicated that they were more likely to disclose sensitive data when facilitated by practising general practitioners, so all focus groups were led by two general practitioner researchers. Many of the participants knew each other.

Facilitators used a brief topic guide, although participants were encouraged to talk freely. Personal and practice information was gathered by questionnaire (see bmj.com). The discussion was recorded and transcribed in full.

Analysis

The constant comparative method was used, guided by framework analysis. A coding frame was independently developed by each researcher, and the final version of codes agreed through discussion. Underlying themes emerged iteratively as the groups progressed. The constant comparative method was used to form a consensus and to inform the sampling strategy for subsequent groups. A matrix was constructed for each of the eight main themes that emerged, allowing comparison across groups for each theme. See bmj.com for details.

Results and interpretation

Strategies for implementing the system, and continuity of care

General practitioners developed either fixed or flexible certification strategies, based on acquiescence, negotiation, and challenging requests (box 1). Fixed strategies such as always acquiescing seemed to be pragmatic ways to minimise the stress of deciding how to behave on a case by case basis. These approaches seemed to be

Box 1: Strategies for implementing system, and continuity of care

Group 1 (Tayside, urban)

GP3: I've no discrimination at all, if a patient comes in and says "I need to be off for two weeks ... with a cold," I'll give him a Med 3 no questions asked.

Group 3 (Highland, mixed)

GP4: She said "Do you think that I should just take a week off sick; because, what else will I do?" And we just talked through it ... And eventually she decided, oh yes, it is a good idea to stay working.

GP2: So another doctor may have easily just given her that line within the first two minutes.

Group 8 (Highland, urban)

GP6: I don't think there is anything wrong with saying to people "You seem to me to be fit" ... because if you feel you are being bullied, maybe you need to stand your ground.

Group 6 (Highland, rural and remote)

GP6: She is going around all the doctors trying to get somebody to agree with her that she needs to be off sick.

Locum group (Highland)

GP6: Practices differ ... If you've got a very busy surgery and run 5 minute appointments, you've got much more compromises in what you do. If you've got a very slow 15 minute appointment system you can spend a lot of time, sorting things out.

Box 2: The doctor-patient relationship and certification

Group 2 (Highland, mixed)

GP8: How can we act as policeman, friend, social worker and all the rest of it? We can't.

GP6: I very rarely refuse to supply a certificate ... I'm not going to allow a small issue like that to interfere with my relationship.

Group 4 (Glasgow, urban)

GP1: Once a patient didn't come to me for ten years because of me refusing her a sick line.

Registrar group (Glasgow, urban)

GP4: Established GPs don't tend to fight.

related to workload and location. Generally, in more rural practices, continuity of care was reported more often, and general practitioners were more likely to approach certification flexibly. This was viewed as patient centred and could be stressful. It included strategies for challenging patients or negotiating strategies, both of which required time, continuity of care, and knowledge of the community.

The doctor-patient relationship and certification

Most participants believed that their responsibility to the patient outweighed that to the Department of Work and Pensions and Department of Social Security. Almost all described strong conflicts of interest (box 2). They often described feeling they were endangering the doctor-patient relationship when challenging patients. A few commented that doctors find not being liked difficult. It was pointed out that general practitioners see communication as one of their core or defining roles, and that they experience it as a failure if that breaks down. To most participants the sickness certification system, in which external judgment is a central component, was the antithesis of patient centred communication and decision making.

Use and misuse of system by general practitioners

Knowledge of the system was poor and lack of interest stated (box 3). There seemed to be a code or "language of sick lines" which fulfilled three purposes: to preserve patient confidentiality, to communicate with other agencies, and to deliberately misuse or sabotage the system by the use of vague diagnoses. Participants described writing "malaise," "debility," and "TALOIA" (there's a lot of it about), producing meaningless statistics. The strategy of acquiescence to every patient can also be seen as a form of sabotage, rendering the gatekeeping role useless. Participants related their misuse of certification to frustration with its irreconcilable requirements. (Although participants were interested in the concept of training on certification, they did not wish to learn about a system that they perceived to be flawed.)

How general practitioners make judgments about certification

Participants normally took a compassionate approach towards certification (box 4). Although many judgments were straightforward, some difficult or dubious requests for certification posed problems. Many participants made a value judgment that patients' lives would be better if they were able to work. They described conflict between their advocate role as a doctor and their

Box 3: Use and misuse of sickness certification system

Group 2 (Highland, mixed)

GP7: I've just given up worrying about whether I'm acting as the gatekeeper to the DSS system or benefits agency system ... Patient wants a line, that's fine, here you are.

Facilitator: So that's for any length of time, so it's patient-led?

GP7: Yes ... I think often what we write down is rubbish ... there there must be an epidemic of "malaise." If they produce government figures to say these are the illnesses that keep people off work, then I can't see that they're any use at all.

Locum group (Highland)

GP1: I've stopped filling it in and never had a problem.

Facilitator: You say you don't write anything? You leave it [diagnosis section] blank?

GP1: I've been doing this for about 4 months now and I've not had any returned yet.

role as judge. Most of the participants did not see making judgments on behalf of the Department of Work and Pensions or employers as a core role.

Who is in control of the situation?

Participants described several stakeholders in the sickness certification system that may have differing agendas. These included employers, patients, relatives, the acute sector, the Department of Social Security, the Department of Work and Pensions, the Benefits Agency Medical Service, overseeing authorities (for example, the aviation authority), and society. Participants described feeling ill used by the demands placed on them by these groups (box 5). Some felt pressurised into writing lies and other illegal behaviours such as providing certificates without seeing the patient. They perceived a loss of personal and professional control and felt caught between factions. Where overt benefit fraud occurred, general practitioners had no satisfactory mechanism for dealing with it. Two participants described patients taking legal action against them or their partners for refusing to condone applications for sickness benefit or appeals against Benefits Agency decisions.

Interaction with colleagues

Participants felt undermined and undervalued by hospital colleagues and other health and social service agencies (see box 5) and were critical of those who

Box 4: How general practitioners make judgments about certification

Group 1 (Tayside, urban)

GP3: I don't feel on the one hand you can say to somebody, "well you know you're genuinely ill I agree you should be off work" and say to somebody else "well you're telling me you're ill and on balance, yes OK I'll sign you off" and then say to somebody else "well I don't believe you." How can you actually differentiate?

Group 10 (Tayside, urban and rural)

GP7: Often the earlier you get them back (to work) the better for the patient, but I don't care as far as the company goes.

delegated certification to them. The only colleague consistently appreciated was the (defunct) regional medical officer, to whom general practitioners had previously turned for specialist advice. Doctors from the Benefits Agency Medical Service who replaced regional medical officers were rated as much less effective. General practitioner registrars felt undermined by principals and their trainers. This contributed to the disillusionment associated with the development of the less challenging attitude towards sickness certification held by more experienced general practitioners. Locums reported fewer grievances.

What is the scope for change?

About half the participants wished their certification role removed. Many thought an extension of self certification the best alternative. Frequently expressed was the need for a personally known authoritative individual to whom they could refer (such as a regional medical officer). Some participants considered that other healthcare workers could provide sick certificates to patients, but the participants in partnerships described numerous instances of patients "shopping around" for certificates. Other suggestions included the streamlining of forms, better occupational health and rehabilitation, further training, sick line clinics, general practitioner time in a "regional medical officer hat," and copying other countries' systems.

Box 5: Control of situation and interaction with colleagues

Group 3 (Highland, mixed)

GP3: You're putting your professional reputation on the line over something ... over which you have no control.

Group 6 (Highland, rural and remote)

GP4: An independent medical examination found that she was unfit for work because of her backache; with no objective evidence. When I spoke to that consultant on the phone and said we have been struggling for ages to get her off the sick, he said "it's easier on these people just to let them off." He made an arbitrary decision.

Group 7 (Tayside, rural)

GP2: The employment office says "you go and see your doctor and get signed off, then you won't appear on our unemployment statistics."

Registrar group (Glasgow, urban)

GP1: He was much better ... and I refused to give him a line. Two days later he saw one of the other GPs and he got a line! And I said "why did you give him a line?" and he says, "You'll learn."

Discussion

Variation exists in the practice of sickness certification both between and among doctors.⁸ Our participants confirmed that the system is largely patient led, and that they found judgments difficult where there were no objective signs.¹¹⁻¹³ We used a collaborative, multicentre method for researching sensitive professional issues in general practice. Many of our findings supported those of the only other comparable study commissioned by the Department of Work and Pensions.¹⁴ Some of our data and conclusions are, however, significantly different. By using general

practitioner interviewers we were able to gather more sensitive data and to canvas more extreme views and practices. We found that the focus group method encouraged confession in a peer led environment.¹⁵

Significant new findings

Straightforward sickness certification is not a problem. However, our participants reported that for the significant minority where difficult decisions exist, any or all of the stakeholders involved may substantially misuse the system. Among the reasons why general practitioners misuse the system participants cited patient confidentiality, stress, demands on time, avoiding conflict in the doctor-patient relationship, disillusionment with the system, and undermining of their decisions. The participants particularly resented the effect of their certification role on the doctor-patient relationship and also resented making judgments for other agencies. They had developed individual ways of using the system, largely unrelated to guidelines. Many made patient advocacy a priority and issued sick certificates on demand. By doing this they undermined the intended gatekeeper role.

Implications and implementation

Our findings may have several implications for policy makers planning both future research and strategies: extra training for its own sake is unlikely to be effective until underlying problems for gatekeepers are addressed. Alternatives to the gatekeeper system could include a self certification system with spot checks (akin to tax self assessment). If the gatekeeper system is continued, problems must be resolved—namely, pressurising of the gatekeeper by other agencies, the lack of accessible and authoritative support for the gatekeeper, and the ability of the consumer to “shop around,” weakening the gatekeeper role.

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Ethical approval: Not required.

1 *A Guide for registered medical practitioners*. London: Executive Agency, 2000. (No IB204 DSS.)

2 Department of Work and Pensions. *Client group analysis: quarterly bulletin on the population of working age on key benefits—May 2002*. London: DWP, 2002.

What is already known on this topic

The cost of sickness absence to developed countries is high

Only a proportion of people certified as sick can truly be regarded as unfit for work due to medical reasons

General practitioners are unhappy with their current certification role

What this study adds

General practitioners develop individual ways of operating sickness certification; in practice most operate a “sick certificate on demand” system

All stakeholders, including general practitioners, may seriously misuse the system

Consideration of underlying issues is pivotal to proposed changes—for example, increasing sources of sick certificates will further undermine the gatekeeper role

- McEwan IM. Absenteeism and sickness absence. *Postgrad Med J* 1991;67:1067-71.
 - Mayhew HE, Nordlund DJ. Absenteeism certification: the physician's role. *J Fam Pract* 1988;26:651-5.
 - Larsen BA, Forde OH, Tellnes G. Legens kontrollfunktion ved sykmelding. *Tidsskr Nor Lægeforen* 1994;114:1442-4.
 - Feeny A, North F, Head J, Canner R, Marmot M. Socioeconomic and sex differentials in reason for sickness absence from the Whitehall II study. *Occup Environ Med* 1998;55:91-8.
 - Reiso H, Nygard JE, Brage S, Gulbrandsen P, Tellnes G. Work ability assessed by patients and their GPs in new episodes of sickness certification. *Fam Pract* 2000;17:139-44.
 - Tellnes G, Sandvik L, Moum T. Inter-doctor variation in sickness certification. *Scand J Prim Health Care* 1990;8:45-52.
 - McCormick, J. *On the sick: incapacity and inclusion*. Edinburgh: Scottish Council Foundation, 2000.
 - Luz J, Green MS. Sickness absenteeism from work—a critical review of the literature. *Public Health Rev* 1997;25:89-122.
 - Wolinsky FD, Wolinski SR. Expecting sick-role legitimation and getting it. *J Health Social Behav* 1981;22:229-42.
 - Chew-Graham C, May C. Chronic low back pain in general practice: the challenge of the consultation. *Fam Pract* 1999;16:46-9.
 - Haland Haldorsen EM, Brage S, Stomme Johannesen T, Tellnes G, Ursin H. Musculoskeletal pain: concepts of disease, illness, and sickness. Certification in health professionals in Norway. *Scand J Rheumatol* 1996;25:224-32.
 - Hiscock J, Ritchie J. *The role of GPs in sickness certification*. London: Department of Work and Pensions, 2001. (Research report No148.)
 - Chew-Graham CA, May CR, Perry MS. Qualitative research and the problem of judgement: lessons from interviewing fellow professionals. *Fam Pract* 2002;19:285-9. (Accepted 11 November 2003)
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One hundred years ago

Automobiles for medical men

A car never gets tired; can be taken out a dozen times a day, and even if never driven faster at any one moment than the best pace of an average horse, it gets over the ground much quicker, owing to the facility with which it threads traffic, and to the fact that it does not slacken pace except over quite steep hills. Moreover, hasty calls can be answered much more quickly, for a car in good order can be got out of the stable and under way at five minutes' notice. Work, therefore, can certainly be got through a deal quicker than in a carriage, with the added advantage that, distance being no object, the day's round need not be arranged more with

a view to saving the horses than to the absolute needs of the practice, and serious cases at any distance can be visited as early and as often as desired. The time saved, of course, is of great advantage, whether it be used for recreation or for other work which otherwise could not be done. There can be small doubt, therefore, that, given a reliable car, automobiles have a distinct advantage in a town practice or in a country one which covers a good deal of ground, but not in a practice which is of such a nature that, if need were, it could either be done on foot or with a cheap pony and corresponding cart. (*BMJ* 1904;i:142)