

Development of ten case studies that reflect the challenges faced by GPs in dealing with employment related issues

**A Report by Isobel MacPherson, Institute of Rural Health
April 2011**

Acknowledgements

Thanks to all the GPs who took the time to complete the survey: it was much appreciated. A very special thanks to those GPs who provided the case studies for their time, and their clarity and honesty about the issues they face in the sickness absence certification process.

To Matthew and the other staff at ONS, a big thanks in trying to create a difficult data set.

To Professor Kristin Alexanderson and Dr Anna Lofgren a huge thanks for allowing us to use some of the survey questions and for the continued interest in the work.

Thanks to Katie at IRH for some great editorial work; to Huw for his technical expertise and to Annie and Jane for their comments throughout and keeping the faith!

The Challenges of Sickness Absence Certification: Developing the Case Studies

Introduction

Public Health Wales commissioned the Institute of Rural Health (IRH) to provide ten teaching cases on the issues surrounding sickness absence certification in Wales. IRH advised that the case studies needed to be anchored in the day to day realities of GP work in Wales, and what was known from previous research about the challenges facing GPs thus broadening the scope of the study to provide a more robust basis. This was done in three ways:

- accessing statistical information on sickness absence patterns in Wales
- considering recent (post1999) research literature on the challenges of sickness absence certification
- a survey of Welsh GPs to establish the context and key issues for them in relation to sickness absence certification

Therefore the development of the case studies comes from a clear Welsh evidence base but is anchored to the wider literature.

Aim

To provide ten relevant case studies on the practice of sickness absence certification that could be used in the education of general practitioner trainees in Wales.

Method

The project employed a multi-method triangulated approach:

1. ***Secondary Data re Sickness Absence rates in Wales (ONS)***: to provide a backdrop to the work describing the nature of sickness absence in terms of male/female patterns; age patterns; numbers/rates of days given; the businesses/industries involved.
2. ***Literature Review (1999-2009)***: for the UK and Europe looking at the range and type of study being undertaken, and within that focusing on three areas: the general issues facing GPs; the patient-specific issues; and the ways in which GPs react to the

challenges. Analysis of this data, in concert with the survey, would provide the key issues for the case studies.

3. ***Survey of general practices (420) in Wales:*** After discussion with the commissioners, within the IRH and with a project advisory group, a decision was made to use GP practices in Wales as the sample frame, and to ask the practice managers to identify one GP within each practice to complete the survey. The survey drew on the Sickness Absence Survey work undertaken in Sweden by Dr Anna Lofgren and Prof Kristin Alexanderson (2007; 2010), on the challenges faced by GPs but also included broader issues in relation to the new Fit Note system, and the training needs of GPs, to provide an additional baseline that could be used for future work. Prof Alexanderson kindly permitted questions from their surveys to be included in the Welsh survey. See Appendix 2 for a copy of the survey and practice letter. The survey was sent by 'e' mail to the practice managers with a cover letter explaining the overall project and the salience of the survey. Analysis of the data from the survey would provide the key issues both general and clinical as a basis for the individual case studies.
4. ***Case Interviews (10):*** with GPs who agreed and were able to provide a teaching case based on a real patient and real set of circumstances. The interview schedule is appended. The schedule was designed to probe the GPs' decision-making process by using a variation on Critical Incidence Technique (Bradley CP 1992) to disentangle how decisions came to be made, and what alternatives, if any, were considered; notes for learning facilitators were also included.
5. ***Teaching Cases (11):*** these reflect the critical incidents interview data and take the trainee through the case in a logical fashion from the overarching background of the patient to how the certification issue arose, to the decision made, the underlying rationale, the alternatives available and the teaching lessons. Facilitators can customise the cases for trainees as they wish.

The Methods in Practice

1. ***ONS Sickness Absence Survey Data:*** the latest year for which figures were available on sickness absence was chosen i.e. January-December 2008. It rapidly became clear both in discussions with ONS staff and in running the data, that while the variables to

describe the data were in the system, the more you moved away from the Wales level, the less 'populated' the tables. Thus, while one could look at each Welsh region, for example Anglesey or Gwynedd, there was a limit as to how far sickness absence data can be analysed. For example, the rate might be available for the total population and usually for males and females but not necessarily by age groups, despite the fact that the actual days taken in sickness absence was available by age group. If one wished to know how many days were being taken, then no data was available, either actual or rates. A similar result arose when exploring the data by occupation and profession. This meant that the findings presented are largely limited to an all-Wales view with only sporadic comment at regional level. It should also be noted that ONS charges a fee for providing data out-with their normal publication parameters and this contextual work fell into the latter category.

2. ***The Literature Review***: this focused on the most recent research in Europe and the UK (1999-2009). By checking the references on each article, the key articles germane to this piece of work were found, of which an overview is provided below. It was notable that until very recently little work had been done in the UK related to the challenges faced by GPs, as opposed to more descriptive facts and figures on days lost, the data on certificates, training and insurance related problems. The research was mostly undertaken in England and Scotland or conducted UK-wide: no recent Welsh study was found in the published data.
3. ***Survey of GP Practices***: 108 practices (i.e. 108 GPs) sent back a reply (26%) after the initial mailing and one follow-up. The response rate is notably poor in comparison with other UK studies (e.g. 42% Wynne-Jones et al 2009) for the same issue and noticeably so when compared with the Scandinavian countries (e.g. 71% Lofgren et al 2007, 61% Lindholm et al 2010). No incentives were offered by any of the projects that might have affected the response rates. The most common reason for not completing, when one was given, was lack of time. The section on the overall survey results shows that there was in fact a reasonable spread of both GP and practice characteristics for GPs completing the survey but that should not mask the low response rate. This is especially disappointing as our Swedish colleagues wish to write a co-authored comparison paper.
4. ***Case Interviews***: 23 GPs (21% of respondents to the survey) offered to help. Their

survey data was analysed with regard to their location, age, length of time working as a GP, size of practice, and the key general and clinical challenges identified by all respondents to the survey. In this way a list of thematic case topics was created and through this method 15 GPs were approached each to provide a very specific case (themes are appended). Of those 15 GPs, 10 provided cases, with another two saying they would do so but were unable to do so in the designated time frame. The main reasons for dropping out were a combination of needing to cover absent partners, the requirements of the flu vaccination programme, being too busy generally, and the unusual weather meaning some surgeries were closed on the dates set for the interview and then became too busy. It should be noted that those who had to pull out were very apologetic and wished to be counted in for any other work on the project. Indeed two GPs kindly offered to do more cases if that were necessary and one GP did supply an extra case. The GP respondents were spread across male (4) and female (6); age groups (26-29 yrs, 30-34yrs, 35-39yrs, 40-44yrs, 50-54yrs, 60-64yrs); and length of time as a GP (1-4yrs, 10-19yrs, 20-29yrs, 30+yrs). There were seven principals/partners and three others (sessional, salaried). They represented rural (3), urban (3) small towns and villages (3) and inner city (1) practices. Most were partners and worked in practices of list sizes: 1,000-3,999 (2) 4,000-6,999 (4) 10,000+ (4).

5. **Case Studies:** there are 11 in total covering the following topics:

- a patient with possible depression
- a patient with drug and alcohol problems
- a patient with back pain
- a patient experiencing stress at work
- a patient with diabetes (known 'disability' but can work: GP's choice of condition)
- a patient who expects certification
- a patient recently made redundant
- a case where there is a difference of opinion on whether the patient can work or not
- a case where there is an issue about the optimum amount of sick leave to give
- a case where the issues are more social than clinical

- a case where the clinical evidence does not corroborate the patient's story

These reflect the concerns of the survey respondents. Each case is around two pages in length and sub-headed. This is deliberate to keep a tight focus but also allow easier customisation.

Data Handling and Analysis

1. **ONS Data:** the researcher worked with a member of the ONS team in Cardiff to create tabular templates against which the Welsh sickness absence could be run and analysed using descriptive and discriminatory statistics as appropriate. Only the descriptive statistics using the 'rates' of days of sick leave are presented in this report by way of general context as it is the most germane to the case studies.
2. **Literature Data:** the relevant articles were each read and thematically coded to reflect three levels: the challenges facing GPs generally; the challenges from patients; and GPs' reactions and strategies. The data was then brought together under these headings to ascertain the commonalities.
3. **Survey Data:** descriptive tables were produced as appropriate using cross tabs to reflect the question and the location of the GP as the key analytic mechanism. Secondary mechanisms included male/female; size of practice and length of service. For the purposes of this report the results and findings are presented at the overall survey level.
4. **Case Interviews:** these were taped and transcribed and then coded accordingly: i.e. deductive under the interview headings and inductively for the emergent themes. This data is used in this report for the individual cases.
5. **Case Studies:** these were paraphrased from each GP interview, reflecting the informal nature of the interview process. To give an overall coherence and focus on similar issues and areas of interest between cases, the studies are organised around the same sub-headings. GPs have been quoted directly where such quotes give insight into their thinking.

Literature Review: Overview of Key Findings

Sickness absence certification has generated a large body of research work concerned with sickness absence, but in the UK, in particular, this has mostly revolved around establishing the facts and figures related to sickness absence, the types of clinical conditions being cited in relation to certification, training issues, and the role of the GP in general. Only recently has the research work in the UK focused on the challenges facing GPs (Hussey et al 2004; Wynne-Jones et al 2009; Toon 2009, Dobson 2010). The main academic work in this area has been carried out in the Scandinavian countries (Tellnes 1989; Timpka et al 1995; Brage et al 1995; Englund et al 2000; Lofvander et al 2003); Lofgren et al 2007, Arrelov et al 2007; Swartling 2008; van Knorring et al 2008; Engblom et al 2009; Lindholm et al 2010). A variety of methods have been used but the main one has been large-scale surveys either presenting vignettes and asking a series of related questions (Englund et al 2000) or presenting a series of statements on the potential issues to be rated by the GP (Lofgren et al 2007; Lindholm et al 2010). More in depth work centred on interviews with small numbers of GPs (Swartling et al 2008) or focus groups (Hussey et al 2004; van Knorring et al 2008). With the exception of the Swedish studies led by Professor Kristen Alexanderson, there have been no recent studies that have looked at the issue over time.

From the findings of these studies the key challenges facing GPs can be summarised as:

- dealing with demanding patients
- role conflict in being the patient's advocate and gatekeeper for the authorities
- handling situations where there are conflicting views as to whether the patient is fit for work
- difficulty in estimating the optimal amount of sickness absence leave to give
- re-certifying patients already on sick leave
- lack of knowledge of the effect of sickness absence certification on the patient's life

The patient-specific challenges facing the GP can be summarised as:

- patient attitudes, for example seeing sickness absence as a right
- patients with no incentive to work
- patients with difficult to diagnose symptoms
- patients who want sick leave for other than clinical reasons
- patients who do not follow recommendations about treatment while on sick leave

- cultural competencies when assessing immigrants
- difficulties in resisting demands if the GP lives in the same community

Very little (Englund et al 2000; Englund et al 2000; Hussey et al 2004; Toon 2009; Wynne-Jones et al 2009) has been written recently about actual GP strategies for coping with the various situations they find themselves in concerning sickness absence certification. In some cases the evidence has to be deduced from the data presented and the tactics are not always explained, simply noted. But the following gives a flavour of the findings:

- older patients receive longer periods of certification
- patients with pain conditions receive the longest certification periods
- unstable working conditions result in longer sick listings
- patient's attitudes to sick listing are highly influential: i.e. demanding patients are more likely to be sick listed
- female physicians sick list more than males
- fixed strategies: GP always acquiesces
- flexible strategies: GPs challenge the patients and negotiate
- use of vague diagnoses to preserve patient confidentiality
- making value judgements as to whether the patient's life would be better if they worked or not
- providing a certificate without seeing the patient
- if the patient initiates the conversation they are more likely to get certification

Overview of Sickness Absence among the Working Population of Wales (ONS) Tables 1-4 (Appendix 1)

Table 1a shows that in 2008 there were just over a million people in work in Wales evenly split between males and females. The biggest proportion of workers was in the age group 40-49 yrs. The younger age groups (<30yrs) accounted for just over a quarter of the total workforce. There were proportionately more females in the working age groups 40-49yrs and 50-54yrs than males but more males in the 60-64yrs age group.

Just 2.1% of the working population had one or more sick days during 2008 and Table 1b shows there was no difference between males and females in this regard. From Table 1b it can be noted the majority of sick days occurred among two age groups those aged 30-39yrs (27.4%) and those aged 40-49yrs (23.3%). The lowest number occurred among those aged 16-19yrs (4%). A closer look at the gender make-up shows that more females in the 40-49yrs group accounted for one or more days off than males in that group.

Table 1c shows the sickness absence rate for the working population as a whole to be 2.1 days with the highest rates among those aged 30-39yrs (2.7 days) and 60-64yrs (2.6 days). The highest rate for males (3.0 days) occurred among those aged 60-64yrs and for females those aged 30-39yrs (2.5 days). The lowest rates for males (1.9 days) and females (1.7 days) occurred within the same age group i.e. 20-29yrs.

Looking at individual regions within Wales we can note that Caerphilly (3.2 days), Torfaen (2.9 days) and Swansea/Cardiff (2.7 days) are the top three regions in terms of sickness absence. In contrast Neath Port (0.9 days), Conway (1.2 days) and Merthyr (1.5 days) have the lowest sickness absence rates. Caerphilly (3.3 days) and Gwynedd (3.2 days) have the highest female rates while Torfaen (4.0 days) and Cardiff (3.4 days) have the highest male rates. In contrast Powys (0.9 days) and Bridgend (1.1) have the lowest female rates with Gwynedd (1.5 days) and Rhondda (1.6 days) having the lowest male rates. Interestingly, within regions there are notable gender disparities: thus women have more than double the sickness absence rate of men in Gwynedd and Swansea; whereas men have more than double the rate of women in Ceredigion, Bridgend and Torfaen.

In terms of occupational groups (Table 3) as defined by ONS, the highest sickness absence rate is among skilled trade occupations (4.1 days), and the lowest rate among the associated professional and technical occupations (1.4 days). The highest rates among females were in elementary occupations (2.8 days) and the lowest among process and plant machine operatives (1.6 days). The highest rates among males were in the personal services occupations (2.3 days) and the lowest among associated professional and technical occupations (0.9 days).

Table 4 shows the sickness absence rates for specific job sectors with the Utilities industry (3.7 days) and the Hotel and Restaurants (3.5 days) having the highest rates. The lowest sickness absence rates were for jobs in the Other Community, Social and Personal (1.4 days). In gender terms, the highest female rates were in jobs in Public Administration and Defence (2.9 days) and for males in jobs in Financial Intermediation (3.7 days) and Health and Social Work (3.6 days). The lowest female rates were for jobs in manufacturing (1.1 days) and the lowest for males in jobs in Other Community, Social and Personal (0.9 days). Again, we can note clear gender splits within job sectors; thus the rate of sickness absence is more than double for females than males in Real Estate, Renting and Business Activity jobs, Public Administration and Defence, Education and Other Community, Social and Personal jobs. The rate of sickness absence is more than double for males than females in Manufacturing, and Financial Intermediation jobs.

The data shows differences not just at the level of gender and age groups but also anchors these differences to regions, occupations and job categories.

Survey of GPs about the Challenges of Sickness Absence Certification: An Overview. Tables 1-8, Appendix 2)

108 GPs responded to the survey and the overview Tables are presented in Appendix 2. Note that the analysis for each table is on those who answered that particular question; not all GPs answered all questions including those in the characteristics sections.

Personal Characteristics: 59% (63) of respondents were male and 41% (43) female. The respondents were spread across the age groups with over half (57%; 60) accounted for by those aged 40-54yrs. The majority of respondents (67%, 67) had been in practice for either 10-19yrs or 20-29yrs. Just over half were principles (55%, 55), and 41% (41) were partners. Forty one per cent (44) were 'urban' practices with just over a third small towns and villages (36%, 30) and just under a quarter (23%, 25) rural practices. A third of respondents (33%, 34) had list sizes of 7,000-9,999 patients and over a quarter (29%, 30) had list sizes of 4,000-6,999 patients. Over half of the respondents (56%, 57) were in practices with 1-4 partners and 43% (44) in practices with 5-9 partners.

Findings

Over two thirds of respondents (68%, 75) had consultations with sickness absence issues more than five times a week and the remainder 1-5 times a week.

The **clinical conditions** causing most problems in terms of assessment and certification were: back pain, depression, anxiety and stress, psychological issues, drug and alcohol abuse.

In terms of **the challenges** facing the GPs the key (very problematic + fairly problematic) concerns in descending order were:

- manage the role of patient advocate and gatekeeper for DWP (89%)
- handle situations where you and the patients have differing opinions on the need for sick leave (85%)
- cope with patients who expect certification as routine (78%)
- handle situations where the sickness absence was more related to non-clinical reasons (76%)
- assess the type of work a patient can undertake (75%)
- assess degree to which reduced functional capacity limits the ability to work (71%)
- assess whether patients' functional capacity is reduced (67%)
- ascertain the optimum duration and degree of sickness absence certification (63%)
- assess the impact of your decision on patients' current socio-economic situations (62%)
- decide whether to authorise prolonging a sick leave period previously given by another GP (58%)
- discuss with patients the advantages/disadvantages of being on sick leave (42%)

Respondents were asked if there were specific **local and cultural factors** which influenced levels of sickness absence certification in their practice areas and a range of issues emerged:

- the lack of employment within an area
- the difficulty of finding appropriate work when the patient has an identifiable physical or psychological limitation
- the nature of the work available in the area i.e. work available locally is low-paid and a better or similar lifestyle can be funded on benefits

- the ‘generational’ effect i.e. no work within a family across two/three generations, leading to a lack of experience of work as routine and normal
- endemic sickness benefit culture within a locale
- living in a deprived area increases the reliance on benefits to live
- culturally acceptable to be jobless and on benefits
- the use of sick-notes by Job Centres to either increase a person’s benefits or as an alternative to being registered unemployed
- the demands of family commitments negating the ability to work
- patient assumptions that ‘being unwell equals a sick-note’

Respondents were asked about the level of contact they had and wished to have with others concerned in sickness absence certification i.e. occupational health, employers and DWP staff.

- Occupational Health: 60% (61) of respondents stated they never or almost never had contact with this service. Only 28% (29) were happy with the situation, with 41% (43) wanting more information on the service and 31% (33) wanting more contact.
- Employers: Two-thirds (68) of respondents stated they never or almost never had contact with employers. However 51% (54) were happy the ways things were with 40% (42) wanting more information from employers.
- DWP: 69% (70) stated they never or almost never had contact with DWP staff. Only a third (34%, 35) were happy with this situation while almost a half (49%, 50) wanted more information from DWP staff.

Thus, across the board, approximately two-thirds of respondents had no real contact with other key parties in the sickness absence certification system.

When asked how prepared they felt to implement the new Fit Note system the respondents were fairly evenly split between those who felt prepared (49%, 52) and those who felt unprepared (44% 47) with 6 respondents feeling very unprepared. In terms of what improvement respondents felt the new system would bring to their role, the respondents provided a wide range of expectations of which the following were most commonly cited:

- being able to mention specific duties a patient could or could not do to enable them to

continue working

- making it easier to get patients back to work and back to work more quickly
- enabling phased returns to work
- having fewer appointments for sick notes
- no dichotomy between Med 3 and Med 5 forms
- less paperwork with a simpler form to complete
- ability to assess without having to see the patient
- increasing the responsibility of employers to facilitate a return to work
- no difference

In overall terms respondents hoped the new system would be more flexible, engage employers more, create less paperwork and create a more positive dialogue for the GP, patient and employer.

Two questions were asked in terms of training and information needs. The first related to evidence-based approaches and just over a third (36%, 38) of respondents wanted more information and approximately another third (35%, 37) wanted more training. The second related to knowledge and access to relevant services to get patients back to work and here just over half (52%, 55) wanted more information with just under a third (32%, 34) wanting more training.

In summary: the survey highlighted not just the issues respondents felt were most problematic about certification but also some of the important underlying factors and contexts in their locale.

Case Studies

It is worth pointing out some common aspects related to the teaching cases:

- All the cases are complex, covering layers of issues and therefore each can be used to illustrate a number of themes, not just the set issue. Thus they are reflective of the complexities the GPs in Wales, and elsewhere, face on a daily basis
- The cases point to wider dilemmas created by the certification system which will not necessarily be addressed by the changes, for example the tension between wanting to

be tough on certification versus the economic imperative if the patient chooses to retaliate and leave the practice

- The impact of different strategies operating within one practice allowing patients to play GPs off against each other
- The coping mechanisms respondents employed to justify/rationalise difficult decisions tend to have common features such as restricting certification periods
- The creativity of patients when they are determined to get certification
- The need to look at the big picture within a case: for example, will giving or not giving certification facilitate other more important developments in the patient's other clinical issues or within their wider life

In Conclusion

The ONS data has shown the regional and occupational variation in sick days taken by those in employment in Wales and the GPs have highlighted their concerns in certification both clinical, social and procedural. Many of these reflect the findings of other research studies but also reflect the socio-economic circumstances of the practices and their patients. The cases reflect both the complexity of the work of Welsh GPs in sickness absence certification, the realities behind their decision-making and the issues they feel are important to share and discuss.

Sickness Absence Certification: Literature and References

Pre-2000 (selective key citations)

1984

Condren L, Cox J, McCormack JS, Sullivan A (1984) Certification of Unfitness to Work. *International Medical Journal*; 77:p159-60

1989

Tellnes G (1989) Sickness certification in general practice: a review. *Family Practice*; Vol 6, No 1: 58-65

1992

Bradley CP (1992) Turning anecdotes into data: the critical incidence technique. *Family Practice*; 9: 98-103

1993

North F, Syme SL, Feeney A, Head J, Shipley MJ, Marmot MG (1993) Explaining socio-economic differences in sickness absence: the Whitehall II study. *BMJ*; Vol 306: 361-6

1995

Brage S, Haland Haldorsen EM, Johannesen TS, Ursen H, Tellnes G (1995) The use of case histories to explore concepts of disease, illness, and sickness certification. *Family Practice*: Vol 12, No 1:75-83

Timpka T, Hensing G, Alexanderson K (1995) Dilemmas in Sickness Certification among Swedish Physicians. *European Journal of Public Health*; Vol 5, No 3: p215-219

Post-2000 (selective key citations)

2000

Englund L, Svardsudd K (2000) Sick-listing habits among general practitioners in a Swedish County. *Scan J Prim Health*; 18, Issue 2: 75-79

Englund L, Tibblin G, Svardsudd K (2000) Variations in sick-listing practice among male and female physicians of different specialties based on the use of case vignettes. *Scan J Prim Health*; 18, Issue 1: 48-52

2003

Lofvander M and Engstrom A (2003) An Observer-participant study in primary care of the assessments of inability to work in migrant patients with ongoing sick leave. *Scan J Prim Health Care*; 21: 199-204

2004

Alexanderson K, Norlund A (2004) Chpt 1 Aim, Background, Key Concepts, Regulations and Current Statistics. *Scand J Public Health*; 32 (Supp 63): 12-30 (note this is part of a systematic literature review on sickness absence causes consequences and physician practices)

Hussey S, Hoddinott P, Wilson P, Dowell J, Barbour R (2004) Sickness certification system in the United Kingdom: a qualitative study of the views of general practitioners in Scotland. *BMJ*; 328: 88-93

2007

Arrelov B, Alexanderson K, Hagberg J, Lofgren A, Nilsson G, Ponzer S (2007) Dealing with sickness certification-a survey of problems and strategies among general practitioners and orthopaedic surgeons. *BMC Public Health*; 7:273-282

Lofgren A, Hagberg J, Arrelov B, Ponzer S, Alexanderson K (2007) Frequency and nature of problems associated with sickness certification tasks-a cross-sectional questionnaire study of 5455 physicians. *Scan J Prim Health Care*; 25:178-185

2008

Editorial (2008) Medically certified sickness absence. *BMJ* 337:1174

Head J, Ferrie JE, Alexanderson K, Westerlund H, Vahtera J, Kivimaki M (2008) Diagnosis-specific absence as a predictor of mortality: the Whitehall II prospective cohort study. *BMJ*; Online:1-7

O'Brien K, Cadbury N, Rollnick S, Wood F (2008) Sickness certification in general practice consultation: the patient's perspective, a qualitative study. *Family Practice*; 25: 20-26

Stafford N (2008) Danish government turns to doctors to tackle rising absenteeism from work. *BMJ*; 336: 908-909

Swartling MS, Alexanderson KAE, Wahlstrom RA (2008) Barriers to good sickness certification: an interview study with Swedish general practitioners. *Scand J Public Health*; 36: 408-414

Von-Knorrung M, Sunberg L, Lofgren A, Alexanderson K (2008) Problems in sickness certification of patients: a qualitative study of the views of 26 physicians in Sweden. *Scan J Prim Health Care*; 26: 22-28

2009

Engblom M, Alexanderson K, Rudebeck CE (2009) Characteristics of sick-listing cases that physicians consider problematic-analysis of written case reports. *Scan J Prim Health Care*; 27:250-255

Toon P (2009) 'I need a note doctor' : dealing with requests for medical reports about patients. *BMJ*; 338: 175

Wynne-Jones G, Mallen CD, Main CJ, Dunn KM (2009) Sickness certification and the gp: what really happens in practice. *Family Practice*; 0:1-9

2010

Dobson R (2010) GPs want more help and training in sick note certification. *BMJ*;

Editorial (2010) From sick notes to fit notes. *BMJ*; 339:b3114

Lindholm C, Arrelöv B, Nilsson G, Lofgren A, Hinas E, Skaner Y, Ekmer A, Alexanderson K (2010) Sickness-certification practice in different clinical settings: a survey of all physicians in a country. *BMC Public Health*; 10: 752

Appendix 1: Sickness Absence Statistics For Wales 2008: National and Regional

The information supplied by the Office of National Statistics Cardiff and is Crown Copy Right

Table 1: Sickness Absence Days Taken and Rate by Male/Female and Age Groups: Wales (2008)

January-December 2008 APS

SEX Sex by AGE Age
for Wales, Employee, Weighted Sum of Person, by PWT07 Person weight

Employee level (INECAC05)

	16 - 19	20 - 29	30 - 39	40 - 49	50 - 54	55 - 59	60 - 64	65+	Total
Male	26846	125994	125496	139282	59041	50660	33023	10007	570349
Female	32344	116836	123165	153027	63217	50388	24203	8120	571300
Total	59190	242830	248661	292309	122258	101048	57226	18127	1141649

Sickness (one day or more) ILLOFF

	16 - 19	20 - 29	30 - 39	40 - 49	50 - 54	55 - 59	60 - 64	65+	Total
Male	529	2380	3599	2366	1162	1107	995	-	12138
Female	668	2011	3087	3307	1404	915	480	322	12194
Total	1197	4391	6686	5673	2566	2022	1475	322	24332

Sickness Absence Rate									
	16 - 19	20 - 29	30 - 39	40 - 49	50 - 54	55 - 59	60 - 64	65+	Total
Male	2.0	1.9	2.9	1.7	2.0	2.2	3.0	-	2.1
Female	2.1	1.7	2.5	2.2	2.2	1.8	2.0	4.0	2.1
Total	2.0	1.8	2.7	1.9	2.1	2.0	2.6	1.8	2.1

Table 2: Sickness Absence Overall Rates by Welsh Region and Gender 2008)

	Male	Female	Total Population
Anglesey	-	-	-
Gwynedd	1.5	3.2	2.4
Conway	0.9	1.5	1.2
Denbighshire	1.9	2.1	2
Flintshire	2.1	1.8	2
Wrexham	2.1	2.4	2.3

Powys	2.4	0.9	1.7
Ceredigion	2.1	1.5	1.8
Pembrokeshire	-	-	1.9
Carmathern	2.2	1.9	2
Swansea	1.8	3.7	2.7
Neath Port	-	-	0.9
Bridgend	2.7	1.1	1.9
Vale of Glamorgan	2.4	2.4	2.4
Rhondda	1.6	2	1.8
Merthyr Ty	-	-	1.5
Caerphilly	3.1	3.3	3.2
Blaenau Gwent	2.6	2.1	2.4
Torfaen	4	1.8	2.9
Monmouth	-	-	2
Newport	2.2	1.3	1.7
Cardiff	3.4	2	2.7

Table 3: Sickness Absence Rates for ONS Occupational Groupings: Wales (2008)

	Males	Females	Total Occupational Group
Managers and Senior Officials	1.3	2	1.5
Professional Occupations	2	2.2	2.1
Associated Professional & Technical	0.9	1.9	1.4
Administrative & Secretarial	2.1	2.2	2.2
Skilled Trades Occupations	-	-	4.1
Personal Service Occupations	2.3	2.2	2.2
Sales & Customer Service Occupations	2.2	1.7	1.9
Process & Plant Machine Operatives	1.8	1.6	1.8
Elementary Occupations	2.1	2.8	2.4

--	--	--	--

Table 4: Sickness Absence Rate by Main Job Sector: Wales (2008)

	Male	Female	Total Job Sector
Agriculture, Hunting & Forestry	-	-	-
Fishing	-	-	-
Mining & Quarrying	-	-	-
Manufacturing	2.7	1.1	2.4
Electricity, Water & Gas	-	-	3.7
Construction	-	-	2.5
Wholesale, Retail & Motor Trade	2	2	2
Hotels & Restaurants	1.3	2.4	3.5
Transport, Storage & Communication	2.1	1.8	2.1
Financial Intermediation	3.7	1.8	2.7
Real Estate, Renting & Business Activity	1.1	2.3	1.7
Public Administration & Defence	1.2	2.9	2.1
Education	0.8	2.4	1.9
Health & Social Work	3.6	1.9	2.2
Other Community, Social & Personal	0.9	1.9	1.4
Private H/Holds with Employed Persons	-	-	-
Extra Territorial Employment	-	-	-

Appendix 2: GP Case Based Interview Schedule: Sickness Absence Project

1. **Case Overview:** e.g. age, sex, marital status, work status, type of work, relevant health/clinical information and duration, relevant medication/intervention/treatment information, currently off sick or not, previously certification history if known, known family circumstances, other relevant information.
2. How did the patient first present e.g. clinical/health?
3. How did the issue of Sickness Absence first arise in the consultation? E.g. patient had been referred for sickness absence certification assessment; patient asking for sickness absence; patient asking for continuation of sickness absence period; emerged in consultation; GP had to suggest
4. What was the GP's initial reactions to request/possibility of sickness certification and why?
5. What did the GP judge the effect of the patient's 'health' etc would have on their ability to work? Was that a difficult judgement to come to in this case?
6. What information did the GP have to hand to make a decision? Any gaps?
7. What options were open to the GP in considering the request?
8. What did the GP decide to do and why/why not?
9. Did the GP consult with others, gather other data before making a final decision? If so who was consulted/what was gathered and why?
10. Did consulting with others or gathering more data influence the sickness absence certification decision?
11. What ultimately happened? E.g. granted certification etc?
12. What was the patient's reaction? (i.e. acceptance, rejection, non committal)
13. If rejection, non-committal, how did the GP deal with that?
14. How did the GP feel about the outcome?
15. Did the GP get a sense of how patient felt about the outcome?
16. Would the GP have done anything differently in hindsight?
17. What are the key discussion points in the case?
18. Is there anything the GP would do differently if she or he came across a similar case again?

The Challenges of Sickness/Absence Certification: GP Survey: Wales 2010

(Note all figures refer to the number answering that question or part thereof)

Table 1: Respondent and Practice Characteristics

a) Gender (N=106)

	Male	Female	TOTAL
TOTAL	63	43	106

b) Age Group (N=106)

	26-29yrs	30-34yrs	35-39yrs	40-44yrs	45-49yrs	50-54yrs	55-59yrs	60-64yrs	65yrs+	TOTAL
	1	13	12	22	17	21	9	8	4	107

c) Years as a GP (N=105)

	<1yr	1-4yrs	5-9yrs	10-19yrs	20-29yrs	30yrs+	TOTAL
	1	15	12	31	36	10	105

d) Type of Contract (N=99)

	Principal	Partner	Session	Salaried	TOTAL
	55	42	2	3	101

e) Practice Location (N=107)

	Remote	Rural	Small T&V	Urban	Sub-Urban	Inner City	(All Urban)	TOTAL
	0	25	38	30	10	4	44	107

f) List Size (N=104)

	<1,000	1,000-3,999	4,000-6,999	7,000-9,999	10000	TOTAL
	0	18	30	34	22	104

g) Equivalent Partners (N=102)

	1-4 partners	5-9 partners	10+ partners	TOTAL

	57	44	1	102
--	----	----	---	-----

Table 2: Frequency of Consultation involving Sickness Absence

	More than 5 Times per Week	1-5 Times per Week	Approx Once per Month	Few Times a Year	Never, Almost Never	TOTAL
	71	35	0	0	0	106

Table 3: The Challenges Facing GPs: How Problematic?

a) assess whether patient's functional capacity is reduced

	Very	Fairly	Not Very	Not At All	TOTAL
	20	51	33	3	107

b) assess degree to which reduced functional capacity limits ability to work

	Very	Fairly	Not Very	Not At All	TOTAL
	23	51	26	3	103

c) assess type of work patient could undertake

	Very	Fairly	Not Very	Not At All	TOTAL
	33	47	24	2	106

d) discuss with patient the advantages/disadvantages of being on sick leave

	Very	Fairly	Not Very	Not At All	TOTAL
	13	31	48	13	105

e) cope with patient who expects certification as routine

	Very	Fairly	Not Very	Not At All	TOTAL
	42	40	21	3	105

f) assess impact of your decision on the patient's current socio-economic situation

	Very	Fairly	Not Very	Not At All	TOTAL
	10	54	39	1	104

g) manage role of patient advocate/physician and gatekeeper/medical expert for DWP

	Very	Fairly	Not Very	Not At All	TOTAL

	49	43	12	1	105
--	----	----	----	---	-----

h) decide whether to authorise prolonging a sick leave period previously given by another GP

	Very	Fairly	Not Very	Not At All	TOTAL
	14	47	43	1	105

i) ascertain the optimum duration and degree of sickness absence certification

	Very	Fairly	Not Very	Not At All	TOTAL
	21	46	38	1	106

j) handle situations where you and the patient have differing opinions on the need for sick leave

	Very	Fairly	Not Very	Not At All	TOTAL
	38	50	16	1	105

k) handle situations where the sickness absence is more related to reasons other than clinical

	Very	Fairly	Not Very	Not At All	TOTAL
	25	54	25	1	105

Table 4: The Ten Clinical Conditions Causing Most Problems in Assessing Fitness to Work

<i>Clinical Condition: Rank Order Descending 1-10</i>
Back Pain
Depression
Anxiety
Stress
Work Related Stress
Psychological/Mental Health
Drug and Alcohol Abuse
Post Operative Issues
Arthritis
Joint Pains

Table 5: GP Contact with Occupational Therapy, Employers and DWP

	Occupational Health	Employers	DWP Staff
Daily	0	1	1
Weekly	2	0	1
Monthly	2	5	7
Few Times a Year	38	31	24
Never, Almost Never	65	70	74
TOTAL	107	107	107

Table 6: GPs Desire for More Contact/Information from OH, Employers and DWP Staff

	Occupational Health	Employers	DWP Staff
More Contact	33	9	18
More Information	43	42	50
Happy Way Things Are	29	54	35
TOTAL	105	105	103

Table 7: How Prepared Do GPs Feel to Implement the new Fit Note? (N=106)

	Very Unprepared	Unprepared	Prepared	Very Prepared
	6	47	52	1

Table 8: Would GPs Like More Information and Training On:

a) Evidenced Based Approaches to Getting Patients Back to Work (N=106)

	More Information	More Training	Happy as Are
	38	37	31

b) Knowledge and Access to Relevant Services to get Patient back to Work (N=106)

	More Information	More Training	Happy as Are
	55	34	17