Exploring how General Practitioners work with patients on sick leave

A study commissioned as part of the ‘Job Retention and Rehabilitation Pilot’ evaluation

Alice Mowlam and Jane Lewis

A report of research carried out by the National Centre for Social Research on behalf of the Department for Work and Pensions
Contents

Acknowledgements ........................................................................................................... v
Authors ......................................................................................................................... vi
Summary .......................................................................................................................... 1

1 Introduction ................................................................................................................... 7
  1.1 Objectives and background to the study .......................................................... 7
  1.2 The study design ............................................................................................... 8
    1.2.1 Sampling ....................................................................................................... 8
    1.2.2 Fieldwork ..................................................................................................... 10
    1.2.3 Analysis ....................................................................................................... 10
    1.2.4 The structure of the report ......................................................................... 11

2 Influences on the management of sickness absence .................................................. 13
  2.1 GPs’ perceptions of patients on sickness absence ............................................ 13
    2.1.1 Conditions and patients ............................................................................ 13
    2.1.2 Perceptions of patient motivations and attitudes ....................................... 14
  2.2 GPs’ views about the therapeutic value of work .............................................. 16
    2.2.1 The clinical benefits of work ..................................................................... 16
    2.2.2 When work is not beneficial ...................................................................... 17
    2.2.3 Influences on views about the therapeutic value of work .......................... 18
  2.3 Constraints on involvement in work issues ....................................................... 19
    2.3.1 The doctor-patient relationship .................................................................. 19
    2.3.2 Time constraints ....................................................................................... 20
    2.3.3 Limited occupational health expertise ....................................................... 21
    2.3.4 Constraints on continuity of care ............................................................... 21
  2.4 Views about the scope of the GP role ................................................................. 22
  2.5 Chapter summary ............................................................................................... 23

3 Managing sickness absence ....................................................................................... 25
Acknowledgements

We are very grateful to the GPs who gave their time to be interviewed for this study, and to their colleagues who helped to co-ordinate interview arrangements. We were conscious, in carrying out the research, of the time pressures under which GPs operate and greatly appreciate their willingness to make time to be interviewed.

We are also very grateful to Roy Sainsbury and Kath Nice at the Social Policy Research Unit at the University of York for their collaboration in the study. They worked with us on the design, carried out half the fieldwork and analysis, and provided very helpful comments on the interpretation and draft report. Their role as members of the research team was very influential and we are grateful to them for their collaboration.
The Authors

Alice Mowlam, National Centre for Social Research
Jane Lewis, National Centre for Social Research
Summary

Objectives and background (Chapter 1)

The purpose of this study was to explore general practitioners’ (GPs’) approaches to managing sickness absence and to assisting patients in returning to work. The objectives were: to explore the roles they play; their perception of the extent of their remit; the types of discussions they have with patients; the factors that influence their approaches and how they work with other specialists or organisations. The study involved in-depth interviews with 24 GPs, purposively selected from a national database of GP surgeries. Key sampling criteria were: the location of the GP practice; the number of partners; the extent of GPs’ experience and any specialist expertise in occupational health. Interviews took place between October and December 2004 and the data were analysed using Framework.

Influences on the management of sickness absence (Chapter 2)

Dealing with sickness absence was a daily issue for GPs. Most absences were said to be short, involving issues such as acute episodes, chronic conditions, broken limbs and post-operative recovery. More problematic and sometimes lengthier absence was particularly associated with back pain, depression, stress and anxiety. GPs commented on the rising prevalence of absence due to workplace stress arising from poor relationships at work, and rising workloads and pressure. The view among GPs was that sickness absence is almost always genuine. However, patients’ behaviour and motivation was said to be influenced by issues such as subjective reactions to the experience of illness, organisational culture and financial circumstances.

There was a widespread view among GPs that work can be of therapeutic benefit for a range of physical and psycho-social reasons. This view was qualified, however, where patients worked in low-paid jobs of low social status, and where the job itself caused or exacerbated a physical or psychological condition. GPs’ own personal views about the value of work, as well as observations of patients and research, were influential here.
Four key factors were identified, to varying degrees across the sample, as constraints on GPs’ involvement in return to work issues. The importance of preserving the doctor-patient relationship, based on mutual trust and an assumption that the doctor is acting in the patient’s best interests, was stressed. GPs sometimes saw a conflict between their obligations to patients and either the benefits system or employers. Shortage of time also made it difficult for doctors to address work thoroughly, and there were references to the new GP contract not funding work rehabilitation activity. It was felt that their limited occupational health expertise made it difficult to give advice about the interaction between a condition and work, and there were some concerns about litigation. Finally, doctors highlighted the difficulties in providing continuity of care and building up in-depth knowledge of a patient.

These considerations underpinned different views about the extent to which work rehabilitation is part of the GP role. At one end of the spectrum were doctors who took a holistic viewpoint, seeing work as an important element of health. They saw aiding patients to return to work as an integral part of medical rehabilitation. At the other end of the spectrum were doctors who felt that their role was to focus on medical rehabilitation. Although a return to work might follow from this, work issues were not in themselves seen as part of the GP remit. In between were GPs who, to varying degrees, saw their remit as involving work issues, but a dominant theme here was the doctor-patient relationship. This, together with other constraints and sometimes a more qualified view of the therapeutic benefits of work, meant that these doctors saw work issues as part of their role only to a limited extent.

Managing sickness absence (Chapter 3)

There were differences among GPs in their approaches to assessing fitness for work. One group relied on the patient’s own assessment, arguing that the patient is the best judge of their condition and its impact on their capacity for work. This did not necessarily mean, however, that they did not address work issues. An alternative approach was for the GP to form their own judgement of the patient’s fitness for work through questioning the patient closely about their symptoms and their work.

GPs sought information about patients’ occupations to varying degrees, some as part of their assessment of the patient’s fitness for work and others to identify obstacles that needed to be addressed or strategies for helping the patient to return to work.

There appeared not to be a return to work dimension to doctors’ clinical treatment of patients either themselves or in terms of NHS referrals. Indeed they strongly emphasised the importance of equality of treatment and felt that providing treatment on the basis of working status would be wrong. There were some reports of working more proactively with patients with a job to return to, or making referrals with a higher degree of urgency, but, in general, work issues appeared not in themselves to influence clinical treatment decisions.
There were a range of strategies for addressing patients' motivations to work. GPs talked about suggesting, encouraging, questioning or challenging patients, with varying degrees of firmness. Sickness certification was sometimes used actively to manage patients' expectations and the timescale of their return to work, where GPs gradually shortened the duration of certificates or warned the patient that they were on their penultimate or last sick note. There were different approaches to using Med 3 forms for a phased return. Some GPs used them to inform employers that the patient could return on a phased return or signed the patient back on a part-time basis, but there was also a view that it was only possible to certify patients as able to resume work on the basis of their full duties.

A further strategy involved using the benefits system to reinforce doctors' encouragement of patients to return to work. Here GPs alerted patients to the fact that the assessment of their fitness for work changes at six months and that the patient might, therefore, be found fit for work. Some also initiated an earlier Personal Capability Assessment (PCA). This was seen as a way of encouraging a return to work without putting pressure on the doctor-patient relationship.

There was diversity in how far GPs advised on the process of a return to work by, for example, identifying barriers to, and strategies for, returning to work. There were different views about whether it was appropriate to suggest alternative job directions if a patient could not return to their former work, and concerns that the scope for doing so is limited without occupational health expertise.

GPs took different approaches to liaising with employers and providing reports. One group of GPs saw initiating or responding to contact as an opportunity to recommend ways in which the patient could be supported in returning to work. But there were concerns about such contact and doctors generally encouraged patients to take the lead. Time, confidentiality and potential conflicts of interest were relevant here. Some doctors stressed that they approached writing reports as 'the patient's advocate' and were accordingly guarded in what they wrote. Experiences of employers and occupational health services were mixed.

The stage at which work was raised by GPs varied. It could be raised right from the beginning of the absence and returned to frequently; raised at a specific point such as after a couple of weeks, or when a medical specialist had indicated that a return to work would be expected; or the timing could be influenced by the doctor's or the patient's assessments of fitness for work.

The most proactive group of doctors described detailed discussions of work with patients, often from early on, and included doctors who initiated contact with employers. Some here stressed their use of iterative, persuasive, in-depth communication addressing patients' concerns; others seemed to be more ready to use sickness certification or referrals for PCAs to reinforce their own messages. The least proactive group of doctors described no discussion of work or limited discussion, either when the issue was raised by patients or in rare circumstances when the absence was flagrantly illegitimate. In between were doctors who...
discussed work to some degree but who would not proceed if they met with resistance from the patient. They described raising work so that the patient was clear about their options but felt the extent to which they could persuade or help was limited.

These different approaches largely reflected the doctors’ individual views about whether work was part of their remit, and about the extent of constraints on their involvement in work rehabilitation. There were no particular patterns in the characteristics of GPs in each of the three groups: all three groups included doctors in different types of surgeries and, perhaps surprisingly, doctors with occupational health expertise. However, the three more recently qualified doctors were all more proactive in their approach to work.

Working with others (Chapter 4)

There was very limited awareness of the role of Jobcentre Plus. Doctors described having suggested a visit to the Jobcentre when patients could not return to their previous work, but there was a widespread assumption that Jobcentre Plus provides support only to unemployed people.

Some doctors knew of Job Retention and Rehabilitation Pilot (JRRP) services and had encouraged patients to use them, but experience was generally limited. There were some misunderstandings about the type of support the services provide. Despite the fact that GPs often saw at least some limitations to their own involvement in work rehabilitation, the idea of additional specialist services met with a mixed reception. There was sometimes strong support for the idea but others doubted that specialist provision would add much or that patients would use it, and it was clear that for some working with such a service would not be a priority.

Conclusions and recommendations (Chapter 5)

The GPs interviewed described a range of approaches to managing sickness absence, and it is clear that there are some significant constraints to their work, although some appear able to overcome these. A range of policy options suggest themselves if GPs are to be encouraged to place more emphasis on work rehabilitation.

First, there appears to be scope to reinforce messages about the therapeutic value of work and to raise awareness about the financial support available to make work pay. What seems to be more important, however, is addressing assumptions about how far work can be promoted within a constructive doctor-patient relationship. This might involve educative work to support GPs’ negotiating skills and identify strategies for communicating with patients. An alternative approach would be to introduce a more structured and prescriptive approach to GP consultations.
There is a need for increased occupational health training, and perhaps scope to underline the value of different clinical approaches to helping patients to return to work. Sickness certification and work rehabilitation are not seen as well resourced aspects of GPs’ work and this may need to be addressed in GP contracts and by providing funding incentives. GPs’ responsibility for sickness certification and absence management fits within the holistic model of health that is adopted by some GPs. However, given the diversity of views and approaches, it may be worth considering whether this should become an optional, and separately funded, aspect of their work, although this may not be feasible and clearly would not be consistent with holistic models of primary healthcare.

GPs’ work with employers could be supported through promoting effective strategies and examples of good practice, joint training sessions, and using sickness certification documentation more consistently to make recommendations to employers. Improving employer practice would also be important to raise the credibility of employers, and of working with them, among GPs.

The data suggests there is a role for specialist work rehabilitation services particularly to provide assessments of capability and the occupational implications of conditions; advice about graded returns and alternative job routes; mediation between employers and employees; faster access to clinical help, and a more work rehabilitation focus to specialist health care. However, the task of bringing them to the attention of GPs and encouraging them to make use of them is a significant one. Finally, there is clearly scope to raise awareness of the role of Jobcentre Plus, and the distance between GPs and the Department for Work and Pensions (DWP) is striking.
1 Introduction

1.1 Objectives and background to the study

The purpose of this study was to explore General Practitioners’ (GPs’) approaches to managing sickness absence and assisting patients to return to work. The aims were to explore:

- the roles that doctors play in working with people who are off sick from work;
- their perceptions of their role and remit in relation to aiding returns to work as distinct from medical rehabilitation;
- the types of discussions they have with patients about returning to work;
- the factors that influence, prompt or constrain GPs’ approaches;
- how GPs work with other health care professionals, specialist vocational rehabilitation or occupational health services, employers and employer-based occupational health staff.

The study took place against a background of rising Incapacity Benefit registers and growing interest in the adequacy of vocational rehabilitation provision, signified by a framework for vocational rehabilitation developed by the Department for Work and Pensions (DWP, 2004). A key part of the context for the study is the Job Retention and Rehabilitation Pilot (JRRP), under which vocational rehabilitation services funded jointly by the DWP and the Department of Health have been provided in six areas since April 2003 for a pilot period ending in March 2005. There have also been a number of information campaigns directed at GPs by the DWP aiming to stimulate more active management of sickness absence.

In addition, there is a growing body of research exploring the role that GPs play in sickness certification which points to the non-medical factors taken into account (Hiscock and Ritchie, 2001; Hussey et al., 2004; Sawney, 2002). There is also debate about the nature of the relationship between GPs and occupational health professionals which points to generally limited contact and potential conflicts of interest (Beaumont, 2003; Sawney and Challenor, 2003).
1.2 The study design

The study involved 24 in-depth interviews with GPs. In-depth interviews were chosen as the appropriate research method for detailed investigation of GPs’ approaches and decision-making, and the influences on them.

1.2.1 Sampling

The JRRP is an important part of the background for this study and the study was undertaken as part of a wider programme of research exploring the pilots and their operational contexts. The study, therefore, took place in five of the six areas in which JRRP services operate: Glasgow, Tyneside, Teeside, Sheffield and West Kent.

A comprehensive register of all general practices provided by a specialist health information company was used as the sample frame. This lists information about, and contact details for, over 10,000 practices in the UK. The sample was purposively selected to ensure that key variables which were thought likely to influence practices and approaches were represented. Since the study used qualitative research, it was neither necessary nor desirable to generate a statistically representative sample. However it was important that the sample should be broad based and include a diversity of characteristics and types of GP practices and of individual GPs. For this study, it was decided that the key sampling variables would be:

- in relation to the location of the GP practice:
  - population density;
  - level of deprivation;
- in relation to the practice:
  - number of partners;
- in relation to the GP:
  - number of years in general practice;
  - specialist qualification or interest in occupational health.

Quotas were set for these variables. It had been intended to include a sub-set of practices which ran specialist clinics which might suggest a stronger vocational rehabilitation focus, but the sample frame did not identify any such practices within the five study areas.

The approach procedure involved a letter sent to the senior GP partner and the practice manager outlining the study and inviting a GP in the surgery to participate. (Both letters are reproduced in Appendix B.) GPs were offered an honorarium of £75 for participating. A period of a fortnight was allowed for surgeries to opt out, by contacting the DWP to indicate they did not want to take part. The letters were then followed up by telephone calls to the practice manager or senior partner to ascertain whether a GP would be willing to participate and to arrange an appointment time.
Recruitment proved very challenging. A total of 138 letters were sent out and followed up because of the high number of surgeries which declined to participate or where, after a number of contacts, no response was forthcoming. The research teams logged over 300 individual telephone calls to the surgeries – likely to underrepresent the total number of calls made. The main reason for practices not participating was pressure on the time of GPs. The sample profile is shown in Table 1.1. The final sample had slightly fewer GPs with under eight years’ experience and slightly fewer working in areas of low deprivation, than had been intended.

The fact that the participation rate is relatively low raises questions about how representative the sample is. It is possible that the focus of the study on returns to work was of less interest to doctors who place least emphasis on vocational rehabilitation or management of sickness absence. In practice, however, the interview data highlights a range of views about GPs’ remits in this respect and a range of approaches, from those who see work as largely outside their remit, to those who take a more proactive approach.

### Table 1.1 Sample profile

<table>
<thead>
<tr>
<th>Sampling variable</th>
<th>Number achieved</th>
<th>Quota set</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population density</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>11</td>
<td>5+</td>
</tr>
<tr>
<td>Suburban</td>
<td>6</td>
<td>5+</td>
</tr>
<tr>
<td>Rural</td>
<td>7</td>
<td>5+</td>
</tr>
<tr>
<td><strong>Index of multiple deprivation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>11</td>
<td>5+</td>
</tr>
<tr>
<td>Medium</td>
<td>9</td>
<td>5+</td>
</tr>
<tr>
<td>Low</td>
<td>4</td>
<td>5+</td>
</tr>
<tr>
<td><strong>Number of partners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single partner</td>
<td>5</td>
<td>5+</td>
</tr>
<tr>
<td>Two to five</td>
<td>11</td>
<td>5+</td>
</tr>
<tr>
<td>Six plus</td>
<td>8</td>
<td>5+</td>
</tr>
<tr>
<td><strong>Number of years in general practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under eight</td>
<td>3</td>
<td>5+</td>
</tr>
<tr>
<td>Eight to 19</td>
<td>12</td>
<td>5+</td>
</tr>
<tr>
<td>20+</td>
<td>9</td>
<td>5+</td>
</tr>
<tr>
<td><strong>Specialist qualification or interest in</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>occupational health</td>
<td>4</td>
<td>3+</td>
</tr>
</tbody>
</table>

Four doctors had specialist training or experience in occupational health or had worked as doctors in employer organisations, and two had experience of involvement in medical assessments for the DWP.
The environments within which the practices were located were very varied. At one end of the spectrum were practices in affluent areas: ‘leafy suburbs’ or quiet, residential neighbourhoods, characterised by GPs as having low levels of unemployment and with patient caseloads described as mostly middle class. At the other end of the spectrum were practices in extremely deprived neighbourhoods, with high levels of unemployment, where misuse of drugs and alcohol was reported as being widespread. Ethnically mixed populations, some with high numbers of recent immigrants were also described in some of these areas.

All the GPs worked with other primary health care professionals at their practices, with the range of services largely dependent on the size of the practice. Some of the bigger practices had extensive teams on site, ranging from benefits advisers, osteopaths, counsellors, clinical psychologists, community psychiatric nurses, dieticians and nursing teams (community nurses, health visitors and practice nurses). Smaller practices tended to have nursing teams on site, with access to other primary health care services in the surrounding community.

1.2.2 Fieldwork
The fieldwork took place between early October and early December 2004. Interviews took place at GP practices. The researchers asked for hour long appointments which meant that the actual interview time was around 45 – 50 minutes; some GPs were able to give a little more time and some a little less. The interviews were conducted using topic guides which listed the issues and sub-topics to be explored, without prescribing question wording or order. Responsive questioning and probing was used to ensure relevant topics were covered in depth. The topic guide is reproduced in Appendix C.

Interviews were tape-recorded, with participants’ permission, and transcribed verbatim. Tape-recording raised some issues, which are outlined in Appendix A.

1.2.3 Analysis
The data was analysed using Framework, a systematic and comprehensive method for classifying and interpreting qualitative data (Spencer et al., 2003). The first stage of analysis involved familiarisation with the data and identification of key emergent issues. A series of thematic matrices or charts was then drawn up, each covering one key theme with columns representing sub-topics and rows representing individual interviews. The data from each interview were then summarised in the appropriate cell, with the context retained and the transcript page noted. The charts were stored in Microsoft Excel. The charted data was then reviewed to:

- explore the range of comments made under each sub-topic;
- explore individual cases in detail;
- identify the factors which influence approaches;
- make comparisons between cases and groups of cases.
1.2.4 The structure of the report

Chapter 2 looks at the influences on GPs’ approaches to managing sickness absence. The chapter looks at perceptions of patients on sickness absence and the views and factors which influence GPs’ approaches. Chapter 3 then describes their actual management of sickness absence, looking at decisions about fitness for work, information sought about jobs, clinical work, how patient motivation to return to work is addressed, GPs involvement in the process of returning to work and how they work with employers. Chapter 4 focuses on whether, and how, GPs work with other organisations and individuals in helping patients to return to work, looking at referrals to health care professionals, use of Jobcentre Plus services, and contact with specialist vocational rehabilitation services including JRRP services. It also draws together views about whether additional specialist services are needed. Finally, Chapter 5 discusses the findings and their implications.

Throughout the report, verbatim quotations from interviews are used to illustrate points made in the text. These are shown in italics. The criteria for selection of quotations are discussed in Appendix A.
2 Influences on the management of sickness absence

Chapter 3 looks at how, and how far, GPs actively manage sickness absence by addressing motivations to work and facilitating the return to work. First, though, this chapter looks at the broader context within which GPs work with patients on sick leave and the factors which influence their attitudes and approaches. As elsewhere in the report, the focus is on working with patients who have a job to return to.

The chapter begins by looking at GPs’ perceptions of patients on sickness absence, their attitudes and motivations towards returning to work and particularly the influence of financial considerations. Section 2.2 then explores GPs’ attitudes towards the therapeutic value of work. Section 2.3 discusses factors which are viewed as constraints on their involvement in work rehabilitation. Section 2.4 then looks at GPs’ views about the scope and remit of their role in work rehabilitation and describes three broad sets of attitudes. These form important background context to the practices described in Chapter 3.

2.1 GPs’ perceptions of patients on sickness absence

As explored in the introduction, the sample of GPs included in this research was diverse, including GPs with ranging years of experience, working in different sized practices and in a variety of geographical areas. Despite the diversity of the sample, perceptions of patients on sickness absence were remarkably consistent.

2.1.1 Conditions and patients

Dealing with patients on sickness absence from work was said to be a daily concern for GPs. Although they did not know what proportion of their caseloads this constituted, they talked about working with patients on sick leave in every surgery session. Estimates of the number of such patients varied between one and six per session, although not all would have been people with jobs.
Most absences from work were described by GPs as lasting no more than a few weeks. The sorts of problems commonly referred to were acute episodes, such as chest infections; chronic conditions such as asthma, diabetes, heart conditions or high blood pressure; broken limbs; and post-operative recovery. While the management of chronic conditions could be complex, GPs reported that these conditions were generally quite straightforward and uncontroversial in the sense that patients presented with tangible symptoms and there was a fairly clear clinical pathway for recovery.

However, some conditions were associated with a more problematic, and sometimes lengthier, sickness absence. Back pain and conditions such as depression, stress and anxiety were recurrently highlighted here. GPs described such conditions as more challenging in the sense of it being harder to make a clinical assessment of the condition, its impacts on the patient, the likely duration and the appropriate treatment pathway. Back pain was mentioned by some GPs as an area which had been a focus for treatment initiatives. In these cases, a framework for treatment had been developed for a local area, with clear action to be taken at each step of the clinical pathway. This approach was reported to have had considerable impact, both on the numbers and the frequency of patients being seen for back problems and on the length of the sickness absence.

### 2.1.2 Perceptions of patient motivations and attitudes

A very widespread view among GPs was that patients’ motivations for seeking sickness certificates were almost always genuine. They said that it was rare to encounter a case where the patient was clearly ‘malingering’. However, they noted that the reasons for a person not feeling able to be at work could be very complex, including issues such as difficulties in personal relationships, bereavement, caring for someone who was seriously ill or being affected by their illness, stress or difficulty in managing family demands, and misuse of drugs and alcohol. To varying degrees they felt these were important considerations. They were particularly emphasised where GPs adopted a more holistic or a bio-psycho-social model of health, seeing health as involving not just the absence of physical illness but also psychological and social wellbeing.

Despite the consensus that the vast majority of cases are genuine, however, GPs noted a range of factors which can affect patients’ responses to ill-health.

They commented that all individuals react differently to illness. GPs described how they could see two patients with the same condition, one of whom felt able to continue working while the other did not. Individual motivation and work ethic were seen as relevant here as well as varying thresholds amongst individuals for pain, stress and anxiety.

It was also said that different organisational cultures can influence behaviour. For example, it was widely said that public sector employees take more frequent sick leave, and more time off when they are ill, than private sector workers. GPs were not
necessarily implying that this time off was not authentic, but they were highlighting that organisational cultures and approaches affect behaviour by influencing what is seen as appropriate. They talked about different standards of normal or acceptable behaviour being established in different organisations, for example through the behaviour of employees and managers.

GPs also talked about some patients falling into ‘the sick role’. This phrase was used to allude to a set of psychological responses to ill-health where patients do not see themselves as responsible for their own condition; see their illness as exempting them from their usual everyday functioning; do not necessarily see illness as an undesirable state; and do not feel a strong obligation or motivation to recover. As a result, the longer the patient was absent from work, the harder they could find it to go back—even if the problem that had caused the absence in the first place had been resolved. Patients were described as growing accustomed to being off work, with significant motivation required to move back into work.

The financial impact of being off sick from work was also seen as an important influence on patient motivation. A number of issues were raised here. First, GPs highlighted that some patients are very reluctant to take time off sick because of the resulting financial penalty. This was noted particularly where people had high financial commitments and in relation to self-employed people, who GPs said were rarely off sick. The duration of employer sick pay provision was also seen by GPs as influencing patients’ motivations and behaviours. On the one hand it could result in patients being off for longer than the GP felt they would have been without employer sick pay. On the other hand it could also lead to patients returning to work sooner than they might have done, and sometimes sooner than the GP felt was wise, because of financial pressure:

‘I think you [ie as a patient] can psyche yourself up even thinking, ‘Well, I’ll have to go back after the three months’, and, you know, some people might be going back when they shouldn’t be but other people who perhaps could have gone back at two months will think, ‘Ooh, I’ve still got full pay’.’

GP with eight to 19 years’ experience, practice with more than five partners, urban area of high deprivation

The issue of compensation for workplace accidents was also seen as relevant. GPs referred to cases where they thought the fact that the patient had a compensation claim against the employer had led to them staying off longer than might have been expected. One GP, for example, described a case where the patient had not followed the expected clinical pathway in terms of their recovery, and felt that the fact that they had a direct financial interest in the severity of their condition was relevant.

Finally, some GPs also said that patients could be better off on benefits than in work, and felt some were reluctant to return to work as a result, the implication being that patients would prefer to apply for Incapacity Benefit. These views generally appeared to be based on doctors’ perceptions of and assumptions about benefit levels, rather than on a detailed understanding of the system or of patients’ financial situations.
These attitudes led some doctors to a degree of scepticism about the motivations of patients on sickness absence. Despite this, however, GPs were firmly of the view that it was very rare to encounter a case where the patient was clearly abusing the sickness certification system. There were some obvious exceptions, where GPs had refused further certification, for example where they had seen patients whom they had signed off sick doing other work, or had seen patients with supposed mobility problems either up on roofs or walking without any difficulty. One doctor, for example, described having followed a patient out of his surgery and seen that, on leaving the building, the patient’s limp disappeared. But the general view was that it was more common to find patients who returned to work, or who wanted to return to work, before the GP considered them fit to do so.

2.2 GPs’ views about the therapeutic value of work

2.2.1 The clinical benefits of work

There was a recurrent view among GPs that work could be of therapeutic benefit to patients. A number of reasons were given for this. First, GPs noted a range of psycho-social benefits associated with working. The activity of working and the financial independence it brings were seen as contributing to self-esteem and self-respect and, therefore, felt to be important factors in making people feel valued and in their inclusion within wider society. Having more money from being employed, and a resulting better standard of living, was also itself felt to impact positively on people’s health.

Being off work sick was also widely thought to pose a risk to people’s mental health. This was partly explained by the lack of routine and social interaction resulting from being off work. GPs talked about people being more isolated when not working, and felt that this and having too much time on their hands often led people to dwell on things, and to become more anxious and depressed. Work was described as playing an important role in providing people with a routine as well as a social network:

‘You need a structure to your day to at least go there [to work] to be social, and to contribute to society. When you don’t have a structure to your day, I think these people are more inclined to stay in bed all day, get involved in drugs or alcohol, or they’ve just too much time on their hands, d’you know?’

GP with under eight years’ experience, practice of over five partners, urban area of high deprivation

‘It does people good to go out and play a part in society and to have a role and to mix with other people, it helps keep people well, it keeps them healthy...And a lot of patients realise that themselves, they’re dying to get back to work.’

GP with eight to 19 years’ experience, practice of two to five partners, urban area of high deprivation
GPs also described how being at work could actually constitute an important part of the management of some conditions. Work was seen as helping to sustain people’s physical capacities and aid their recovery, as well as keeping their work skills fresh. Even if the job was not a particularly physical one, GPs talked about the benefits of being active, for example in terms of the journey to and from work. A common example talked about by GPs was back pain. Whilst medical advice for patients suffering from bad backs used to be to refrain from work and to rest in bed, GPs said that evidence now shows that it is better to keep active, and continue with normal day-to-day activities as much as possible. Therefore, depending on the type of activities undertaken, remaining at work could constitute a key element of a treatment pathway for a patient. In addition, there was a recognition that the longer patients were absent from work, the harder it could be for them to return.

Overall, then, there was a clear perception of the potential therapeutic benefits of work – both physical and psychological:

‘I think...if you look at a patient from a holistic point of view, if they’ve got something physical which is stopping them from going back to work, often that has a major detrimental effect on them psychologically… For example, I’ve got a patient...who’s got an arthritic knee...and her employers are going to make some arrangements so that she can get back to work...and I think that that’ll benefit her a lot emotionally and probably have a knock-on effect on her arthritis as well.’

GP with eight to 19 years’ experience, single partner practice, suburban area of low deprivation

### 2.2.2 When work is not beneficial

There were, however, a number of caveats to this. GPs felt that whether work actually was a source of self respect and personal fulfilment depended very much on the type of work being undertaken. These GPs argued that low wage or menial jobs had little social status and did not contribute anything like the same levels of self-esteem that a highly respected job might, and could be bad for people’s mental health in its broadest sense:

‘I don’t think if you have a low paid job when nobody respects you it’s quite the same. I’ve done menial tasks before I went into medicine, I know what it’s like to work long hours for poor pay – not very nice – and people don’t respect you and they have a different attitude towards you based on what you do.’

GP with eight to 19 years’ experience, working in a practice with more than five partners, suburban area of medium deprivation

In addition, some GPs were not at all sure that people were better off being in a low wage job than being on state benefits. They also highlighted that the job was, itself, sometimes the actual cause of the health problem. There were some references to physical conditions here, where work activities either exacerbated or had caused a physical condition. For example, doctors doubted that it would be beneficial for a patient to return to heavy manual labour with a bad back or broken limb, or for
someone with a shoulder problem to return to a job stacking shelves. However, much more emphasis was given to anxiety and stress caused by work as being significant problems. GPs argued that pressures at work were increasing, with rising workloads and higher expectations – and some used their own jobs to illustrate this point. They described seeing a rising number of patients whose absence from work was because of relationship difficulties with work colleagues, bullying, pressure to perform or unrealistic expectations resulting in high levels of stress.

There were different views about whether a return to work could be therapeutic here. Some GPs felt that signing people off sick under these circumstances resulted in unwelcome delay to finding a resolution to the problem. They argued that unless the person was actually there to sort it out, the problem would only be waiting for them on their return to work, which could lead to real anxieties about going back. However, another viewpoint was that some time away from the workplace was necessary if stress undermined their ability to work, and for the patient to recover.

These sorts of considerations and experiences led some GPs to be less convinced of the therapeutic value of work, or to see it as less true in some circumstances.

### 2.2.3 Influences on views about the therapeutic value of work

There were references to research as an influence on GPs’ views. GPs referred to studies which had demonstrated that unemployment was associated with poorer health outcomes. However, they also referred to research which demonstrated that people who retired earlier lived longer, and this was seen as supporting the opposing view: that not working could benefit people’s health.

On the whole, though, GPs said that their views were based more on their observation and experience of working with patients, their wider and more holistic conception of health, and their own personal viewpoints on the merits of working.

Some GPs, for example, talked about having a work ethic themselves, saying that they had always seen work as important. In some cases, this was ascribed to religious values, or more generally to personal value systems and moral codes:

‘I think overall my – and I think it is a moral thing, my kind of vision of a healthy family in the broadest sense a family in a state of well being is more likely to be predicated on employed adults than on unemployed adults. And I think that is a value judgement actually.’

GP with under eight years’ experience, practice with two to five partners, urban area of high deprivation

‘Personal observations I suppose really, thinking about it and reflecting on what’s happened to people over the years. I think being in a place for a long time you can see, you can see the sort of map of people’s lives as the years go by.’

GP with over 20 years’ experience, practice of two to five partners, rural area of low deprivation
Despite this widespread view that work can be of therapeutic value, there were, nevertheless, a wide range of practices in terms of how actively GPs encouraged patients to return to work, as described in Chapter 3. In other words, the view that work can be of therapeutic value did not necessarily translate into active management of patients’ return to work. A number of constraints on involvement in managing sickness absence, leading to different views about whether it is part of the role of GPs, were mediating influences here. These are described in the following sections.

2.3 Constraints on involvement in work issues

Four key issues were raised as constraints on GPs’ involvement in work issues and work rehabilitation. They influenced both GPs’ views about their remit in work rehabilitation, and their actual practices. The issues are the doctor-patient relationship, time constraints, limited occupational health expertise, and the difficulty of providing continuity of care to patients.

2.3.1 The doctor-patient relationship

A recurrent theme was the potential impact of work rehabilitation on the doctor-patient relationship – a phrase used widely across the sample.

At the core of this was the view that the GP and their patient have to trust each other for there to be a workable therapeutic relationship. This hinges on an understanding that the patient is telling the doctor the truth, and that the doctor is working with the patient’s best interests at heart. It was said that the scope to provide effective health care was hampered if this trust does not exist:

‘As a GP you tend to, well you have to, you have to first of all believe that your patient is telling you the truth. If you didn’t accept that your job would be almost impossible, because a lot of what you do is taken from the history to begin with.’

GP with eight to 19 years’ experience, practice with more than five partners, suburban area of medium deprivation

GPs also stressed that they have a professional duty to act in the patient’s best interests and to protect their health – a phrase used recurrently here was that GPs act as the patient’s ‘advocate’. For the GP to get involved in the rehabilitation of a patient back to work, it was, therefore, essential for the patient to believe that the GP was doing this because it was right for the patient, and not because the GP was fulfilling a conflicting professional duty. A number of GPs described, at different stages of the interviews, seeing a conflict in their role between the interests of their patients on the one hand, and those of the benefits system and the employer on the other. These views were discussed in relation to sickness certification, encouraging returns to work and liaising with employers. The phrase ‘policeman’ was used by several GPs who rejected the notion that they should be seen as acting on behalf of either the benefits system or employers:
‘I am not prepared to be a policeman for the government. Really because, my remit in other areas makes it important that I maintain a relationship with that individual patient... I’m talking about a medical relationship. I’m going to see them...in the arena of the consultation, and I’m going to need them on board. Otherwise, first of all, I’m not going to get the correct information out of them, and, secondly, if it does come to a point in time where you need to significantly recruit them in their own treatment, in other words, chronic disease management, or terminal care, or something like that, you want to have a fairly good relationship with them. Whether they are malingerers, work-wise, or not. And so you have to have some sort of detachment, in that respect. And being a policeman for the government would not allow you to have that degree of detachment.’

GP with over 20 years’ experience, two to five partners, rural area of medium deprivation

2.3.2 Time constraints

A further issue, again raised across the sample, was time constraints. GPs talked about the short amount of time they had to see each patient during a surgery session. The ten minutes available for a consultation was seen as insufficient to make a thorough assessment of a patient’s capacity for work or to discuss work options in detail, particularly if the patient was presenting a complex set of issues. In addition, if a surgery was running late, doctors sometimes felt forced to catch up time by dealing quickly with patients on sickness absence, focusing on issuing a new certificate rather than on more active management of the absence.

Dealing with return to work issues was felt to be difficult work which required a careful and considered approach, particularly given the importance of preserving the doctor-patient relationship. This meant that doctors either felt it was not appropriate to expect them to play a large role in work rehabilitation, or that although they ideally might their scope for doing so was severely constrained:

‘I don’t think it’s because I’m not wanting to work in this way... But the bottom line is, with ten minute appointments, to do this sort of work, which is psychological, which is, you know, very, very difficult ... You know, I have in my mind that at the next appointment I’m just going to talk about this and we’ll move forward a little, because it’s always going to be incremental, you know, what are we going to look at this week and so on. But then inevitably they’ll come in the next time and then maybe they’ll have a new physical symptom ... and you’ve got very little time left and so the sicknote just gets signed because you’re actually you’re under pressure.’

GP with under five years’ experience, practice of over five partners, urban area of high deprivation

There were also references to the new GP contracts, which it was said did not fund vocational rehabilitation work by GPs.
2.3.3 Limited occupational health expertise

The GPs interviewed also highlighted lack of expertise in occupational health as a constraint on their remit in relation to returns to work.

Not knowing the actual requirements of different jobs in detail, and the occupational implications of different conditions, meant that GPs felt they had limited understanding of how a return to work would affect their patients’ health. It was difficult for GPs to know what advice they should give about returning to work before the patient was fully fit, or about alternative job directions if the patient’s previous occupation was no longer appropriate. Apart from those with a specialist interest, GPs said that they had received very little training on occupational health issues. This left GPs feeling ill-prepared to play a wider role in work rehabilitation:

‘I guess you are straying into occupational health medicine then [if GPs were to focus more on work rehabilitation]. We’re not specifically trained to deal with workplace issues and health issues in the work. We don’t have the direct knowledge of a person’s job and what it involves and how that affects their health and their ability to get back.’

GP with over 20 years’ experience, practice with two to five partners, rural area of medium deprivation.

Fear of litigation was also mentioned by some doctors. Concerns were raised that the GP’s lack of knowledge of what a patient’s work involved could lead them to make inappropriate recommendations about returning to work. If accident or injury resulted from this decision, GPs saw themselves as potentially liable.

2.3.4 Constraints on continuity of care

Doctors highlighted difficulties in providing continuity of care which could make it difficult to build up in-depth knowledge of a patient or to pursue return to work issues gradually over a course of appointments. This also meant that patients who did not welcome a doctor’s focus on work could find ways of seeing another doctor instead. Two issues were relevant here. First, the requirement for patients to be seen within 48 hours meant that appointments were made with whichever doctor was available. Particularly in larger practices, this was reported as resulting in GPs being less likely to see the same patients on a regular basis. GPs in smaller or single-handed practices, in contrast, felt their practice size helped them to know their patient caseload well.

Second, GPs said that patients could deliberately rotate around different GPs within one practice, or avoid a doctor who was pressing for a return to work. This made it difficult to manage their case consistently or proactively and could easily lead to an absence from work continuing for longer than was reasonable or necessary. One doctor said she dealt with this by giving a short sickness certificate to unfamiliar patients and telling them to return to see their usual doctor. There were some reports of patients choosing to see a particular GP because they were reputed to have a more lenient stance towards signing patients off work. Doctors also noted that patients might choose to change surgery if they did not like the line taken by their GP.
2.4 Views about the scope of the GP role

These considerations underpinned different views about the extent to which work rehabilitation was part of the GP role. An issue explored early in the interviews was whether GPs saw their work as focusing on medical rehabilitation or on enabling patients to return to work. This was clearly not a straightforward issue for the GPs interviewed, and they generally appeared not always to have considered their remit in these terms.

Not surprisingly, GPs felt that at the heart of their role as a general practitioner lay the treatment of their patients’ medical condition. However, beyond this, the extent to which they saw their role as also involving their patients’ work situations varied.

At one end of the spectrum were GPs who approached the treatment of their patients from what was sometimes described as an holistic viewpoint. These doctors argued that a key part of rehabilitating someone medically involved getting them back to their normal day-to-day activities, which, for many patients, meant getting back to work. They saw work as an important element of health and were generally emphatic about its therapeutic benefits. The aims of medical rehabilitation and a return to work could not, therefore, be separated:

‘I don’t think you can divorce the two really [ie medical and work rehabilitation], it’s all part of the person isn’t it, and their life, you are trying to restore them to what’s normal for them, and if that involves a return to work then we hope to achieve that.’

GP with over 20 years’ experience, practice with two to five partners, rural area of medium deprivation

Some in this group of doctors did not mention factors such as the doctor-patient relationship, time constraints, lack of occupational health expertise or continuity of care issues at all as constraints on them. Others referred to some of these issues but this did not undermine their belief in the importance of work as an aspect of health and their belief that they ought to address it.

At the other end of the spectrum were GPs who were clear that their role was just to focus on the patient’s medical condition. Of course, in rehabilitating patients medically, the end result would often be a return to work. But encouraging or facilitating a return to work was not itself something they saw as part of their role:

‘Because it does interfere in doctor-patient relation. [Pause] And if GPs are responsible for the health, and they should be truly and solely responsible for the health. As far as their financial problem is concerned, and as far as their occupational problem is concerned, it should be dealt somewhere outside the GP.’

GP with over 20 years’ experience, practice with two to five partners, urban area of high deprivation
As well as references to doctor-patient relationships, time constraints, limited occupational health expertise and continuity of care, this group of doctors tended to be less emphatic about the therapeutic benefits of work. It was among this group that the concerns about legal liability were expressed. There were also somewhat more negative perceptions of patients, with more references to patients who were felt to be generous in their use of sickness absence or Incapacity Benefit, if not clearly fraudulent. And there was also some scepticism about employers and their willingness to engage fully and supportively with some patients’ returns to work.

Between these two positions was a group of GPs who saw their roles as involving primarily medical rehabilitation but also, to varying degrees, addressing work issues. A dominant theme for this group was the doctor-patient relationship and concern that their role as patient advocates conflicts with their remit in relation to the benefits system and employers. There were again some rather more muted views about the therapeutic value of work, and again concerns about time constraints and lack of occupational health expertise.

Chapter 3 explores doctors’ behaviour in relation to work rehabilitation and looks at the influence of these different sets of attitudes.

2.5 Chapter summary

There was a recurrent view among doctors that the vast majority of sickness absence is genuine. Nevertheless, it was acknowledged that patients do not necessarily respond in the same way to the same condition, that sickness can be a subjective experience, motivation to return to work can vary, and some patients can fall into ‘the sick role’. Financial considerations were seen as an important influence on motivation which can encourage an early return to work, but can also prolong sickness absence. GPs pointed here to the extent of employer sick pay provision, the specific issue of compensation cases, and a view that people may be better off on benefits than in work.

There was a consistent view that work can be of therapeutic value, because of psycho-social benefits and because as an activity it may in itself be rehabilitative. However, this view is more muted for some GPs. A belief in the therapeutic value of work does not appear necessarily to translate into a strong focus on work rehabilitation or active management of sickness absence.

Views about the scope of the GP role in relation to work are varied, and there are different conceptions of the appropriate balance between medical rehabilitation and facilitating a return to work. Medical rehabilitation is seen as central. At one end of the spectrum doctors see facilitating a return to work as an intrinsic part of their role; at the other end it is seen as outside the GP remit.
Four factors in particular are relevant here. First, the importance of preserving the doctor-patient relationship, in which trust is seen as an essential element and the doctor’s duty to protect the patient’s health interests are seen as of greater priority than obligations to employers or the benefits system. Second, GPs stress the constraints on their time. Third, they stress their limited expertise in occupational health medicine. Fourth, there are also difficulties in providing continuity of care, both because of the need to provide appointments within 48 hours and because patients can deliberately avoid a doctor’s attentions by asking for an appointment with a different GP.
3 Managing sickness absence

This chapter looks at how GPs go about managing sickness absence and draws out differences in their approaches. The chapter looks first at how GPs make assessments about a patient’s fitness for work. Section 3.2 looks at how much information they seek about the patient’s job and workplace, and Section 3.3 at their clinical work with patients. The chapter then looks at how they raise the issue of work and aim to address patients’ motivation to work. Section 3.4 looks at the advice they give on how to return to the current job or on alternative job directions. Section 3.5 explores how they work with employers. The chapter ends by drawing out the different approaches of GPs and then by describing patients’ responses.

The study also explored referrals to other health clinicians and whether GPs work with organizations external to the NHS including Jobcentre Plus and vocational rehabilitation services. Because these do not emerge as distinctive elements of managing sickness absence, they are dealt with in Chapter 4.

3.1 Assessing fitness for work

There were differences between GPs in the approaches they described to assessing fitness for work, either when the patient first attended the surgery or when sick notes were renewed.

3.1.1 Relying on the patient’s report

One group of GPs said that they generally relied on patients’ own assessments of whether they were unable to work, although they might question patients about this assessment rather than accepting it without comment. These GPs felt that it was not within their remit to make an objective decision about their patients’ functional or psychological ability to do their job. They felt that the patient is the best judge of their physical or psychological state and its impact on their ability to work, that it is important to trust the patient’s report, and that people very rarely abuse this trust. They also stressed that issues such as pain or stress are subjective experiences, so that it is difficult to question someone’s report of it. Some also said that to question
the patient’s account, particularly when they first ask to be certified off work, runs the risk of damaging the doctor-patient relationship:

‘I think if a patient says it’s too much, it’s too much really... [Otherwise] That’s when you start moving into some sort of assessment process, I feel, which is then questioning what they’re telling you and I’m very reluctant to do that, to ask detailed questions. If they say ‘my job makes my back worse’, then their job makes their back worse as far as I’m concerned...’

GP with under eight years’ experience, practice of over five partners, urban area of high deprivation

This view was underpinned by issues discussed in Chapter 2: the importance of trust in the doctor-patient relationship, not wanting to act as a gatekeeper to benefits, feeling unqualified to make a professional assessment of a patient’s ability to work without training in occupational health, and often being pressed for time so that a lengthy examination or discussion was impossible.

There was also reference to the fact that, after six months, responsibility for assessing capacity for work transferred to the benefits system and that at this point there would be an independent assessment. This meant some GPs felt able to rely on the patient’s assessment, knowing there would be an independent assessment at six months.

This approach of relying on the patient’s own assessment of their fitness for work did not mean that GPs did not raise the issue of work and encourage patients to return to work. Doctors who saw the patient as the best judge of their work capability nevertheless described encouraging patients to see a return to work as inevitable, or stimulated them to think about alternative career paths if their previous occupation was now inappropriate. For example, the doctor quoted above went on to say that, whilst he trusted patients’ assessments of how their condition affected their ability to do their current job, he would still see work as the goal:

‘However, that doesn’t mean that I then say ‘oh, I’ll tell you what, let’s sign you off permanently.’ I’d say ‘well, what are you going to do because you’re 35 and you’ve got a lot of life ahead. Are you intending not to work for the rest of your life or are we going to look at some other options here?’.’

Similarly, there were doctors who said they made objective assessments of fitness for work in making decisions about sickness certification (see Section 3.1.2), but who did not get involved in discussions about work or in-work rehabilitation.

### 3.1.2 Objective assessments of fitness for work

An alternative approach however was more questioning about patients’ capacity for work, either right from the initial request for a sickness certificate or as the absence continued. Here, doctors formed their own judgement about the patient’s capacity for work and would question the patient closely about their symptoms and their job to understand why they were unable to carry it out. They talked about having refused to give certificates on occasions, either initially or later when, in the doctor’s
view, the patient had, or ought to have, recovered sufficiently to return to work. One GP, for example, saw this as central to the credibility of the GP role and not in conflict with the duty to the patient, and was critical of doctors who do not make a proper assessment:

‘I think patients want to feel that we’re taking their condition seriously, actively managing and are prepared to champion their cause where there are real issues between themselves and their workplace. I think patients also need to feel secure that where they are sick, they are going to be protected in that sickness role through certification. And they need to know also that their GP actually is quite prepared to call it a day when. I think we lose credibility in patients eyes, where we’re prepared to sign people off when they don’t merit it... There’s been a lot of publicity about how doctors sign patients off and they don’t bother to examine them, they don’t bother to question or challenge, and that appalls me... And I think that brings a certain security to a patient, that they know that when the doctor feels it’s right to go back to work generally speaking, you know, that will be the time they go.’

GP with eight to 19 years’ experience, practice of two to five partners, rural area of low deprivation

3.1.3 Areas of difficulty

Clinical conditions

GPs said it was easier to judge fitness for work cases with tangible symptoms, such as short-term acute episodes of illnesses like chest infections; chronic conditions, such as asthma, diabetes, heart conditions; broken limbs, which typically resulted in a set period of incapacity; and post-operative conditions, when a patient would often receive recommendations from the surgeon about the length of time they should refrain from work. Conditions such as back pain and depression, stress and anxiety were seen as more difficult and there were divergent views about whether, and in what circumstances, it was appropriate to certify a sickness absence here. It was said that stress could be seen as an inevitable aspect of life and not a clinical condition warranting time off:

‘…and also we will say to people quite often, ‘Well, this isn’t illness. This is a normal reaction that you’re going through…’”

GP with eight to 19 years’ experience, practice with more than five partners, urban area of high deprivation

However, the fact that it could also make people feel incapable of going about their normal day-to-day activities was noted by GPs who argued that there was no point in these circumstances, in forcing a patient to work, and that to do so would worsen their condition. Depression was also highlighted as an area of difficulty in terms of identifying whether or not there is a clinical condition that warrants or will be assisted by a period off work. One doctor, for example, highlighted the importance of distinguishing between depression which is, and which is not, appropriately dealt with by an absence from work:
‘So it’s a matter of teasing the threads out and trying to work out what the best thing is. There’s no point in leaving work if your primary problem is an endogenous depression. It’s not going to get you better.’

GP with eight to 19 years’ experience, practice of two to five partners, rural area of low deprivation

As discussed in Chapter 2, GPs highlighted the prevalence of personal or psychological difficulties arising from the workplace, such as stress caused by pressure of workload or a need to fulfil targets, difficult relationships and bullying. Again, there were some differences between GPs in how they responded to these. Some GPs talked about the importance of exploring this in some detail to distinguish between stress, pressure or unhappiness with a job which might be best addressed by moving to a different job, and conditions such as depression which needed to be treated. One GP said that if he felt someone was trying to ‘medicalise their stress or unhappiness’ about work, he would issue a sick certificate for a week but warn the patient he expected them then to return to work. Other GPs, however, did not describe exploring issues in this depth. They took the view that if a patient said that work-related stress or difficulties meant they were unable to work then they would generally not question that judgement.

Personal issues

GPs also talked about how they took into account personal issues which patients reported as preventing them from working. Again, there were differences in how far they explored them or were aware of them, and how far they saw them as a valid reason for absence from work.

Some GPs stressed that, whilst not an ‘illness’, these were circumstances in which patients often did need time away from work because of relationship difficulties, bereavement or the need to care for a sick child or elderly relative. They felt that it was appropriate to give a sick note here if the patient felt unable to work, and that to force them to work would be counterproductive. The need to take time away from work to care for an ill child or relative was also sometimes referred to here.

There was more debate about patients who misused drugs or alcohol to such an extent that it affected their work. Some GPs were firmly of the view that these patients should not be getting sickness certificates, because they were not ‘ill’. It was felt that this issue highlighted the ‘grey areas’ of sickness certification, where the line between an illness and a social or personal problem became very blurred.

3.2 Seeking information about work

There were also differences among GPs in how much information they sought about patients’ jobs. Some doctors said they would only be looking for the broadest overview of a patient’s work, for example, ascertaining whether they operated machinery or drove where the medication prescribed would impede their ability to do this safely. They did not ask for more detailed information either because they felt their limited knowledge of occupational health meant it would be difficult for them
to use it, or because they felt that this could appear to be challenging the patient’s assessment of their ability to work.

Other GPs, however, did seek more information about work, wanting to know more about the precise nature of a patient’s job and the aspects of it which they were or were not able to do. They did so for different reasons. For some, it was part of making their own assessment of whether or not a patient could work, how long to sign them off for, or to assess whether they could return before they were fully fit. Others placed the emphasis on needing to know about the job to be able to identify strategies for returning, or obstacles that needed to be addressed, which might involve both physical and psychological aspects of health.

### 3.3 Clinical management

GPs’ clinical treatment approaches did not emerge as a distinctive part of managing sickness absence. They emphasised strongly that treating working and non-working people differently would be quite wrong, and against the principle of equality of treatment which was seen as fundamental within the NHS. It was sometimes said that a case where a patient was keen to return to work would be dealt with more proactively in the sense of more regular appointments, or that such cases would not be ‘managed conservatively’. Differences in practice were acknowledged by some GPs in the degree of urgency with which they would make a clinical referral, for example to a physiotherapist or orthopaedic surgeon, or expect it to be dealt with. Some doctors said that if a patient had a job to return to they either would explicitly ask for a referral to be given priority or would indicate that the patient was working in the expectation that this would influence the speed of treatment:

‘I would hope that I would treat my patients equally, regardless of their employment statuses or status. But [pause] maybe...maybe I’m a bit faster...I would refer somebody a little bit sooner, I would be a bit quicker in getting investigations done if they were in employment because I want to try to get them back … so I suppose subconsciously I might sort of think, ‘Well we’ve got to get you back to work here, so we need to get an answer, don’t we. We need to resolve this’. I might refer them to physio sooner, I might refer them to orthopaedic... Yes, I think I probably would.’

GP with over 20 years’ experience, practice of over five partners, urban area of medium deprivation.

However, as Chapter 4 explores, referrals did not themselves generally have a return to work focus.

### 3.4 Addressing patients’ motivations to return to work

GPs described a range of different strategies to address a patient’s attitude or motivation towards work.
3.4.1 Encouraging and challenging

GPs talked about suggesting, encouraging, questioning or challenging patients, with varying degrees of firmness. At the mildest level this would involve simply asking the patient whether they felt able to return to work. Doctors might also ask how much longer the patient felt they would need off work, encouraging them to see the sickness absence as being finite and to recognise that at some point they will need to return to work:

‘Often if someone has been off for a while...several certificates ahead of the final line I’d be saying, ‘Well, we’re going to have to start making a plan and think about getting back to work,’ and that sort of thing and always acknowledging to people that, especially if they’ve been off a long time, that it’s not easy to go back but that it is something which is all part of the process, you know...It’s [a] very loose [plan], it’s just discussing things with them...to plant the seed in their mind and to encourage them to start thinking in that direction. Almost, you know, that it is an inevitability that they’ll need to go back.’

GP with eight to 19 years’ experience, single partner practice, suburban area of low deprivation

They talked about giving strong encouragement to patients to return to work, stressing that it could be beneficial to them physically and psychologically. If a patient’s sickness absence was extending beyond what they viewed as reasonable, they described making comments such as, ‘most people would be ready to go back now’. They also described stressing to patients that they did not have to be completely fit to return to work. A firmer approach described was to say to the patient that the GP thought they were ready to return to work. These doctors also sometimes described encouraging or challenging unemployed patients to think about work.

A more questioning approach was also described, where they would try and find out exactly why a patient did not yet feel ready to return to work, what they felt needed to happen in order for them to do so, and what further help they needed from the GP or from someone else. The purpose here could be either to challenge the patient’s assessment of their fitness for work, or to identify strategies for moving forwards.

Doctors recognised that it could be very difficult for people to feel ready to return to work after a period of sickness absence, and that it could affect their confidence as well as their motivation. They described the importance of exploring people’s reservations or concerns about work, encouraging them to try even a part-time return or to think about a return to lighter duties. One GP said he encouraged patients to try to replicate at home the activities involved in their job, to see for themselves what capacity they had regained, and one described the value of giving ‘healthy, strong reassurance’ about a patient’s physical recovery, saying to a patient:

‘I have just examined you, you’re in tip-top condition. I think your leg is fine ... You can carry on with work and it’s not going to affect you.’

GP with eight to 19 years’ experience, single partner practice, suburban area of medium deprivation
3.4.2 Using the sickness certification process

The fact that patients on sick leave have to return regularly for new sick notes was seen as an important tool in monitoring progress and an opportunity to raise work:

‘...it’s worth remembering that sick notes are also used as a fishing line by the GP to bring a patient back for a review of their medical condition.’

GP with eight to 19 years’ experience, practice with more than five partners, urban area of high deprivation

GPs also described using the sickness certification process more proactively, gradually shortening the duration of sickness certificates to review the patient’s condition more regularly as they recovered and to give the message that a return to work was expected. More directive approaches were also described to managing the timescale of a return to work. GPs said that, if patients responded to the suggestion of a return to work by saying that they thought it was too soon, the GP would find a compromise, agreeing to give one more certificate on the understanding that it was to be the last, or making a file note to have a longer discussion about what was delaying the return to work at the next appointment:

‘...if I really feel that somebody...really needs to get back into work and...the illness is now resolved, and...they really need to get out of their sick role and start getting back into work, sometimes if they’re quite resistant, then we’ll negotiate, what we’ll do is we’ll say, ‘Well, listen...I think you could go back to work in, you know, three or four days,’ and they say, ‘Oh, no, I don’t feel...that’s too soon.’ So I say, ‘OK, well, OK...I’ll give you another week. How about that? And he has an until date.’

GP with eight to 19 years’ experience, practice of two to five partners, urban area of high deprivation.

There were different views about how the sickness certificate document itself could be used if the doctor’s view was that a patient could return to work on a phased return. One approach was to write on the certificate that patients could return to work but only if this was on the basis of a gradual return, with reduced hours or in a limited capacity. Another was to sign patients back to work on a part-time basis. However, there was also a view that it is only possible to certify patients as able to return to work on the basis that they are fit to resume their full duties.

‘We are not allowed to give a certificate to start work on light duties, or half work. So naturally the patients, when they are given a certificate, they will be expected to do their hundred per cent duty. And they are concerned. And that is not our intention either, that a patient should be working a hundred per cent.’

GP with over 20 years’ experience, single partner practice, rural area of medium deprivation.
3.4.3 **Using the benefits system**

More directive approaches described, also involved using the benefit system to support the GP’s encouragement to the patient to return to work. GPs described alerting patients to the fact that their situation will change after six months’ sickness absence, pointing to the fact that the criteria for assessment change, and that the patient might, therefore, be found fit for work. They also highlighted the fact that an independent medical examination would be required at six months and used this fact to encourage the patient to work to an earlier return to work. One doctor said the more prominent use of medical examinations in the benefits system had encouraged him to be more proactive in encouraging patients to return to work, if he doubted they would pass the All Work Test.

The PCA was also sometimes used more actively for managing the sickness absence. A tactic described by some GPs, if they were in some doubt about what the patient reported about their fitness for work, was to precipitate the PCA process by making a request for the assessment to be done sooner. Some GPs told their patients there would now be an independent assessment by a DWP doctor, while others did not and allowed the patient to form the impression that the assessment had been triggered independently of them. The net result, however, was that it took the responsibility for the decision making away from the GP, so that putting pressure on the patient to return to work would not impact on the doctor-patient relationship.

3.5 **Giving advice about the process of returning to work**

3.5.1 **Advising on strategies for returning to the current job**

GPs also described, to varying degrees, getting more involved in advising patients on how to go about making steps towards returning to work. Some described taking a more active ‘problem solving’ approach which involved a detailed discussion to uncover what was holding the patient back from returning to work and suggesting strategies to overcome obstacles. They emphasised the scope for a phased return, exploring what hours or what elements of their work the patient could manage. A key point here was encouraging patients to talk with employers to find ways of helping them to return, for example discussing access issues, the scope for a graduated return, concerns about stress or poor relationships. They also encouraged patients to make use of employer-based occupational health services, to ask for an ergonomic assessment, to talk to unions or to get external help for example from the Citizens’ Advice Bureaux (CAB).

GPs sometimes also talked about discussing relationship or stress-related issues with patients, trying to give them strategies for dealing with these when they return. If the cause of the absence was a problematic relationship at work, some GPs said that they would discuss ways that patients could manage the situation, exploring whether there were people available who might be able to help, or working with the patient directly to develop strategies for coping.
3.5.2 Advising on a change in job direction

There were also different views about the appropriate role of the GP if a patient was not able to return to their original job, or if their work was the root cause of their condition, and the GP felt that changing their job was the best solution. One approach was to get more involved, talking through with patients what type of work they might be interested in, encouraging them to think about retraining and sometimes setting patients tasks such as to investigate a possible job direction or training options before they returned for the next sickness certificate. GPs here would recommend staying in work whilst they were looking, on the basis that it was easier to find a new job from a position of employment rather than unemployment, both from the point of view of a prospective employer as well as the patient’s own motivation and confidence. However, the alternative view was that advice about alternative work fell outside the scope of their role. They felt that it required more knowledge of occupational health than they had, and there was concern about the legal consequences of giving the wrong advice:

‘I think I’d need to realise what my limitations are, and I should not exceed my capacity, and I might be doing wrong otherwise. So I have to be very careful what I advise them, otherwise they might quote me and in the future they might hold me responsible, so I have to be very careful what I say.’

GP with over 20 years’ experience, practice of two to five partners, urban area of high deprivation

3.6 Liaising with employers

3.6.1 Requests for reports and other contact with employers

There were different approaches to initiating or responding to contact with employers. One group of doctors had had direct contact, either initiated by themselves or more usually by the employer. They had written or spoken to employers to support patients’ approaches, or had offered to do so. This contact involved suggesting phased returns, requesting ergonomic equipment or reviews, outlining the capability of employees or making recommendations for facilitating their return. Some felt this was useful and welcomed the opportunity to make recommendations as to the support that would enable a patient to return to work, as well as to learn more about their job. One doctor said he would welcome continuing contact once the patient had returned to deal with any issues which arose. It was also common within the sample for doctors to have been asked to provide reports on their patients for employers.

There were a number of concerns about providing reports and a preference to avoid direct contact with employers, instead encouraging patients to take the lead. Here, doctors were concerned that getting involved with employers directly would be very time-consuming and that it might breach client confidentiality. There was also a view that it was important for patients to take responsibility for the negotiation process themselves, as part of the process of moving towards work. Doctors felt
their own occupational health expertise was limited and were concerned about giving bad advice or felt they had little to contribute. Doctors who took a narrower view of their remit in relation to work rehabilitation saw contact with employers as being outside their scope.

But a recurrent issue was that of conflict of interest. A key issue here was the view that the GP’s role is to act for the patient, not for the employer. Some reassured patients about this, discussed their reports with patients and copied reports or letters to patients either before finalising them or when they sent them to the employer:

‘Well you’re always working for the patient, you’re the patient’s advocate...and that’s sometimes that you’ve got to point out when people give their employer the right to get information from you...And if I do letters I let them see it ..., before I send it back, even though they haven’t requested it.’

GP with eight to 19 years’ experience, practice of over five partners, suburban area of medium deprivation

GPs were conscious, in writing reports, that they were dealing with highly sensitive and confidential information, and some said they were, accordingly, very guarded or ‘cagey’ in what they wrote. There was concern about undermining a patient’s interests by being too forthcoming about their condition, particularly if it was likely they would not be able to return with full function or for some time, and concern if the patient had a condition such as depression which they had not wanted revealed in sick notes. GPs stressed that they would provide accurate information but the implication was that they would not give detailed responses or suggestions.

### 3.6.2 Experiences of employers

The GPs interviewed, generally reported very mixed experiences of employers and of occupational health services. They had found some employers very easy to deal with and described them as flexible, supportive of the employee and clearly keen to help them to return. Other experiences had been less positive. Some employers had been resistant to allowing a graded return or had been otherwise inflexible or unsupportive, and the fact that people returning part-time on a graded return are often not paid their full-time wage was seen as very unhelpful.

Doctors sometimes suspected employers’ motivations. There was a suspicion that at least some employers of ‘having hidden agendas’ and using information provided by GPs to get rid of employees:
‘It’s usually because they’re wanting the patient to leave, so really the negotiations aren’t around getting the patient back, they’re around the patient going. The words...the letters are always phrased in the opposite way, so they always say the right things and use the right phrases around negotiating the appropriate circumstances for the patient returning to work. But in reality that isn’t the case quite frequently, and the reality is that they’re going through with the legal hoops to ensure that at the end of the six months, the patient, or their employee, is able to go without a solicitor breathing down their neck. So you never get the feeling from those letters that it’s truly an altruistic gesture.’

GP with over 20 years’ experience, practice of two to five partners, suburban area of medium deprivation

This was unwelcome in itself and again led to concerns about legal liability.

There was also a complaint that employers use sick leave to deal with performance issues, encouraging employees to go on sick leave to avoid disciplinary procedures. Occupational health departments were sometimes not seen as acting in the patient’s interests, either pressing for a quicker return to work than the GP thought reasonable or being unaccommodating and apparently looking for reasons to terminate employment. Other GPs, however, reported very positive experiences of occupational health services.

3.7 Differences in GPs’ approaches

There was little evidence of GPs not discussing work in some way. GPs pointed out that they had to raise the issue of work, however briefly, in the context of a consultation in which the patient was requesting a sickness certificate. However, there were clear differences among GPs in when they raised the issue of work and how far they went in encouraging a return to work.

3.7.1 The timing of discussions about work

In terms of when the issue of a return to work was raised, there were different approaches:

- raising work as a topic of discussion from the very beginning of the sickness absence and every time a sick note was renewed;

- raising the issue at a specific point: after the patient had been off work for ‘more than a few days’, or for more than a couple of weeks, or at six weeks of sickness absence. In the latter case, the GP would expect to be asked for a medical report by the employer at around this stage, and would tell the patient this;

- raising the issue at the point when other medical professionals, such as surgeons, had indicated that a return to work would be expected;

- raising the issue of a return to work at the point when the GP felt the patient was or should be well enough to return and health was no longer a barrier:
'If I kind of, sort of have a sort of instinct that they’re perhaps more able than they are, giving you the impression they are then you might raise [work] at that point. There are other times when it just probably wouldn’t come up because, as I say, my feeling is that this is not going to be feasible for this person and that’s fine, just keep going.’

GP with eight to 19 years’ experience, practice of over five partners, urban area of high deprivation

• raising work for discussion at the point when the GP felt the absence ‘was no longer legitimate’, when the absence was ‘dragging on’, when the GPs felt that the absence was developing a ‘psychological component’ or there was a danger of the patient becoming stuck in ‘the sick role’.

3.7.2 The extent of discussions about work

Areas of difference

There were also clearly differences in how far GPs went in their discussions in terms of whether they:

• initiated discussion or responded only where patients raised the issue of work;
• went beyond suggesting a return and gave firmer encouragement or direction;
• would pursue discussions when the patient clearly did not want to return to work, at least yet;
• got more involved in advising and suggesting how obstacles might be overcome;
• initiated or responded to contact from employers and were open in writing reports on patients;
• managed the timescale of a return to work by limiting the duration or number of sick notes; and
• would actually get to the point of refusing to give a certificate.

Across the sample, three sets of behaviour could be identified.

Most proactive discussion of work

The first was a group of GPs who were most active in discussing work with patients and encouraging them to return to work. They put a lot of emphasis on encouraging patients, discussing work options and barriers, challenging assumptions about whether work was appropriate, problem solving and helping patients to find strategies for dealing with difficulties. Suggesting a phased return was important here. They described detailed discussions about whether, when and how the patient might return to work. They often started discussing work very early on in the sickness absence and fixed a return to work clearly as the aim.

Among these doctors, some emphasised the importance of making their own judgements about the patient’s fitness for work, and the process of certification was
sometimes used actively to set the timescale for returning to work. Others accepted
the patient’s assessment, but emphasised that a return to work was the aim. In this
group were also doctors who were ready to discuss alternative work options or to
suggest re-training. They sometimes described seeking more detailed information
about work, either to manage sickness certification or to understand how to
facilitate a return. Here too, were doctors who were more proactive in working with
employers, initiating contact or being comfortable to respond to it, although some
preferred the patient to lead on this and there were some concerns.

There were two different emphases within the group. One set of doctors stressed
their use of in-depth iterative discussions with patients and the importance of
working with the patient. The other set seemed to be more ready to use sickness
certification or referrals to the DWP for medical examinations to reinforce the
importance of returning to work.

*Least proactive around work*

The second group of doctors were those who were least involved in discussions
about work, some describing no discussion of work at all. Where they did discuss
work this was only where the patient had first indicated that they wanted to return,
or where they thought sickness certification was being flagrantly misused. Beyond
this, the assumption appeared to be that the patient’s attitude towards returning to
work could not, or should not, be influenced by the doctor. The discussions they
described were limited. Doctors here felt they were not in a position to advise
patients on when they should return to work, nor the type of work. They did not
describe making suggestions for how the patient could return, and one doctor here
understood that it was only possible to certify a patient as fit for work on the basis of
a return to full duties. These doctors mostly described very limited contact with
employers, leaving discussions to patients and responding cautiously to requests for
reports. Their approaches to assessing fitness for work involved relying on the
patient’s assessment, although they withheld certificates if they felt the absence was
clearly not genuine and some also triggered PCAs.

*Ambivalence or caution*

The third group of doctors sat between these two approaches. Although they did
enter into discussions of work, they were more cautious and circumscribed in their
approach than the first group.

Again, there were two sets of approaches. In the first, GPs entered into discussions
of work only once the patient raised the issue, or once they felt the patient was fully
fit, or if they felt the absence was continuing unnecessarily. The second set were
more proactive in raising work and might do so frequently and from early on in the
absence. Discussions were generally less detailed and less emphatic than among the
most active group described above, although some suggested phased returns or
encouraged patients to discuss issues with the employer, and some described
limited discussions about possible alternative work options. But these doctors were
clear that they would not proceed if they met with resistance from the patient. They
described, for example, raising work so that the patient was clear it was an option, emphasising that it was the patient’s choice whether and when to return, and stressing that their approach was not directive. There was also, within the group, some cautiousness about patients returning to work too soon. Overall, the emphasis was on acting in the patient’s interests and as their advocate, although there were also references to other constraints particularly time and occupational health expertise.

This group generally described fairly limited contact with employers. In particular they approached contact with employers or requests for reports from the position of protecting patients’ interests. They were reluctant to give much information, and checked reports with clients or copied them to clients. As in other groups, however, there was a willingness to prompt a PCA if they felt the absence was not legitimate. Some made active judgements in sickness certification, but others followed the patient’s own assessment of their fitness for work.

The three groups broadly correspond with those identified by Hiscock and Ritchie (2001) in their study of GPs’ sickness certification decisions and management of the return to work. They describe three groups: The ‘firm negotiators’ tend to be actively involved in returns to work or job seeking, raising the question of work early and returning to it regularly. Their activities involve goal setting, discussing barriers, referrals to specialists and liaison with employers, and they are prepared to challenge patients and to refuse certificates. ‘Soft negotiators’ take a more flexible, accommodating approach, giving encouragement but concerned not to undermine the patient-doctor relationship. The doctors they describe as ‘non-interventionist’ are strongly influenced by their patients’ expectations and pace. They may give advice and discuss options, but without specific advice or directions, and they do not press where there is a difference of opinion with the patient. They do not generally see the management of returns to work as a key responsibility or a priority.

**Distinguishing between the groups**

Doctors’ behaviour in sickness absence management was strongly linked with their attitudes to work rehabilitation as part of the GP remit as described in Section 2.4. The group who were least active in discussions about work included those who felt most strongly that this type of work did not fall into the GP remit. The middle group who took a cautious approach were those who saw real constraints, particularly the doctor-patient relationship, who were more ambivalent about work being in patients’ best interests and who had qualified views about how far it is part of the GP remit.

The group which was most active in work rehabilitation included the doctors who were clearest about it falling within their remit. They placed most emphasis on work as part of an holistic approach to health, and described few or no constraints to work rehabilitation. However, this more active group of GPs also included a few whose attitudes had been more ambivalent. It is difficult to see what led these doctors to take a more active approach, but it may be relevant that they either had some occupational health specialism or worked in small practices where continuity of care
is less problematic. However, the numbers are small and this cannot be more than a very tentative suggestion.

Also striking is the fact that the group of GPs who were most active in promoting work included all three of the GPs who had more recently qualified, although the sample group here is, again, too small to support firm conclusions about the relevance of this. Beyond this, however, there was no apparent pattern in the characteristics of GPs in each of the three groups. All groups contained GPs in different types of surgeries. Perhaps surprisingly, GPs with occupational health expertise were found in all three groups although again the sample group is small.

3.8 Patient responses

Generally, GPs reported acquiescent responses from patients to the way in which sickness absence was handled. Part of the explanation for this was said to be that patients expected to be asked about their work if they were asking for a sickness certificate to exempt them from it:

‘I mean, if they’re coming in for a sick note, they will expect a degree of grilling of some sort of other...I’ve never yet had anyone who said ‘What the hell are you asking me that for? It’s none of your business’.‘

GP with under eight years’ experience, practice with more than five partners, urban area of high deprivation

In accordance with the view that cases where patients were trying to ‘swing the lead’ were very rare, GPs reported that most people were happy to discuss work and wanted to return. One described the importance, as he saw it, of challenging patients who were anxious or reluctant to return to work, because it could be the push they needed to do something they were scared of and, therefore, unlikely to do on their own. This GP explained that on challenging patients:

‘...most people are pretty amenable. I mean, half the time they’re thinking ‘Gosh, why hasn’t he said this before?’...It’s often all people need to think, ‘Oh, I’ve got to do it.’...or perhaps they’re even thinking ‘The game’s up now, I’ll have to go back.’ It’s almost as though you are pushing at an open door...’

GP with more than 20 years’ experience, practice with two to five partners, urban area of high deprivation

Doctors talked about the importance of judging carefully when to start to encourage a return to work or to challenge a patient’s attitudes or assumptions, and about the importance of a good, supportive relationship with the patient to underpin this approach.

However, they said that some patients did not respond to their overtures or tried to avoid discussion of work, and that others became upset or angry. As noted, there were different responses to this, from backing down to preserve the relationship, to persisting, to ultimately refusing further certificates. Refusing to provide a certificate
was said by some to mean the end of doctor-patient relationship because it signified a breakdown of trust, and these GPs expected that patients would either start to see a different GP within the practice, or would change practice.

In general, it was said to be rare for the situation to become very confrontational, although to some extent this is likely to reflect the approach of some doctors not to push the idea of a return to work if the patient was clearly unhappy with this. Doctors said that it was usually possible to negotiate an approach that was acceptable to both patient and doctor, since there were few patients who were consciously attempting to ‘play the system’.

3.9 Chapter summary

The GPs interviewed describe different approaches to assessing fitness for work. One approach aims to provide an objective assessment of clinical symptoms and their implications for work capacity, with detailed consideration of the requirements of the patient’s job. An alternative approach involves trusting the patient as the person with the best understanding of both their experience of their condition and the requirements of their job. Linked with these approaches was diversity in how far work-related and personal issues are taken into account.

There were also differences among GPs in how much information about work they sought, and whether this was to assess fitness and when a return would be appropriate or to understand and address barriers to work. GPs’ clinical work with patients appeared not to have a distinctive return to work focus, although there was some expectation of speedier referrals where patients had a job to return to.

The doctors interviewed, described a range of approaches to addressing patients’ attitudes and motivations: suggesting, encouraging and questioning with increasing firmness; using the sickness certification process to shorten sickness absence and ultimately refusing certificates; and using the benefit system to address motivation or to create pressure to return to work. There were also differences among doctors in how involved they get in the process of returning to work through making suggestions, problem solving and liaising with employers. There was more doubt about whether it was part of the GP role to make recommendations about alternative work directions, although some doctors did do so.

There are different approaches to liaising with employers. One group of doctors found contact with employers helpful. But there were concerns about conflicts of interests and scepticism about employers’ intentions. Limited occupational health knowledge and time constraints also made GPs reluctant to have much contact with employers.

In general, the preference was for patients to liaise with employers but there were different approaches here.
Three groups emerged in relation to the emphasis placed on work rehabilitation. The most active group generally saw this as clearly part of their remit and described active involvement in sickness absence management. The least proactive either described no discussion of work issues or only addressed this where the patient raised it or in cases of flagrant misuse of sickness absence. Work, for them, was not seen as part of the GP remit. The middle group addressed work to some extent, but the emphasis was on acting as the patient’s advocate and they withdrew if they met with resistance. They were more ambivalent about whether work was part of the GP role and more concerned about conflicts of interest. Attitudes to work rehabilitation were, therefore, of key importance to GPs’ approaches. There is some suggestion in the data that recency of qualification also shapes approaches.

GPs felt that patients generally expected work to be raised and responded acquiescently to encouragement to return. However, the fact that they reported discussions rarely becoming very confrontational is likely in part to reflect a tendency among some to withdraw if they faced strong opposition from the patient.
4 Working with others

This chapter explores the ways in which GPs liaised with other individuals and organisations in managing sickness absence, and particularly in negotiating returns to work. The chapter looks first at referrals to other health care professionals, either within GP surgeries or more widely. Section 4.2 then addresses awareness of and contact with Jobcentre Plus services. Section 4.3 looks at the limited use of vocational rehabilitation services, including JRRP services. The chapter ends by discussing GPs’ views about the need for more vocational rehabilitation provision and the elements they think this should include.

4.1 Health service referrals

GPs described involving a range of different health care professionals, both within their practice teams and externally within the NHS. Within their own surgeries, referrals were made to counsellors, osteopaths, clinical psychologists, dieticians and community psychiatric nurses. Within the NHS beyond their practices, they referred to a wide range of specialists depending on the specific conditions involved: mentioned were physiotherapists, occupational therapists, counsellors, muscular-skeletal specialists, back pain clinics and healthy living centres, psychiatrists, community mental health teams, surgeons and rehabilitation programmes for people with heart conditions.

However, it was very rare for these referrals to be made with a focus on work rehabilitation. The GPs interviewed stressed that their aim in making referrals was clinical recovery, that referrals did not have a particular return to work aim, and that the referral pathway would be no different for patients who had jobs from those who did not. There were exceptions. One GP had referred to a rheumatologist to explore return to work issues, one had used a physiotherapy referral in the same way, and one described referring to a mental health worker to address issues related to work. But in general, health service referrals did not appear to have a distinctive work rehabilitation dimension.
Communication with other clinicians or health professionals appeared to be fairly limited, and, again, not to address work-related issues specifically. GPs described getting reports, but there appeared generally not to be an expectation of on-going communication or liaison about the management of cases. They did not expect feedback from counselling referrals because of client confidentiality.

There were mixed experiences of waiting lists. For example, in relation to physiotherapy GPs reported waiting times varied from a week or two to see a physiotherapist based at the surgery, to 38 weeks for external provision. Similarly, there were references to six to eight weeks wait for practice-based counselling and to waiting lists of four months for external counselling, or six to 12 months for cognitive behavioural therapy. Some patients had used private health care in these circumstances.

4.2 Jobcentre Plus services

There was very limited awareness of the role of Jobcentre Plus for patients who are on sickness absence with a job to return to. GPs generally acknowledged that they knew very little about what provision was available from Jobcentre Plus. Few had ever had any direct contact with Jobcentre Plus staff, and where they had, it appeared to have been around certification or support for people who were not in work. They commented here on difficulties in making contact with the right person and on frequent changes in personnel and the names of services or posts.

Doctors sometimes described having suggested using the Jobcentre to people who could not return to their job and needed to consider retraining or another job direction, and there was one reference to what appeared to be Access to Work although this term was not used. However, there was a widespread assumption that Jobcentres provide job search support only once people have lost their jobs:

‘The problem is that I guess the Department of Work and Pensions see themselves as looking after the unemployed and the chronic sick rather than the short-term sick who are looking to get back into their previous employment. I don’t know whether that’s true or not but I think, that’s how I see it. And so there isn’t really a contact for somebody who’s on the sick but trying to get back into their previous employment. That, I think, is considered to be the role of the employer and it’s only when they lose that job because they’ve been on the sick so long that the Department of Work and Pensions takes over.’

GP with eight to 19 years’ experience, single partner practice, suburban area of medium deprivation

Interestingly, even GPs who had had occupational health expertise who had been involved in Medical Services or appeals tribunals, seemed not to be particularly knowledgeable about Jobcentre Plus provision. Previous terminology such as Disability Resettlement Officer, DHSS, DSS and Employment Service was used widely throughout the sample. There were no references to recent communication initiatives by the DWP such as desk aids or websites.
4.3 Contact with vocational rehabilitation services

4.3.1 Understanding of the term ‘vocational rehabilitation’

The term ‘vocational rehabilitation’ was not one with which the GPs interviewed were familiar. They generally assumed it meant providing different types of support to help people to work, although there were different assumptions as to whether the focus was on returning to any job, to the person’s existing job, to a different job or rehabilitation to perform a particular task. There were also differences in whether they understood it to imply just medical support or broader help. Irving et al. (2004), who explored meanings of the term and alternative suggestions in more detail than the current study, found similar differences in interpretation.

4.3.2 Knowledge and use of vocational rehabilitation services

There was very limited knowledge or use of vocational rehabilitation services (beyond JRRP which is discussed in Section 4.3.3) and it was recurrently said either that there were none in the area or that the doctor did not know whether any existed:

‘They’re [specialist vocational rehabilitation services] non-existent….We would love to have [one].’

GP with eight to 19 years’ experience, practice of over over partners, urban area of high deprivation

There were some references to voluntary sector services which provide employment or job-search support to people who are long-term unemployed, people with enduring mental health problems, and people with drink or drug addictions. One GP had, in the past, used a service provided by occupational therapists and physiotherapists which provided assessment of capabilities and aptitudes but said this had not existed for many years. Only one GP said they were aware of NHS Plus, and none had had contact with it.

4.3.3 Knowledge and use of JRRP services

In three of the four areas there were GPs who were aware of JRRP services, either referring to the Med 3 pads, leaflets, posters or a visit to the surgery by JRRP staff. They had limited experience of the services, usually knowing of just one or two patients who had used them. Those who knew more about the services described them as providing cognitive behavioural therapy, osteopathy, physiotherapy and mediation between employers and employees. Here, views were generally positive based either on support for the concept or positive feedback from patients, and GPs talked about having suggested the service to some patients, although none appeared to do so widely.

Although two GPs had been quite involved with the services and had detailed knowledge of them, others seemed to have more hazy or partial understanding. There were some misunderstandings. One GP appeared to think the leaflets
provided general advice and guidance to patients rather than information about a specific service. Others were unaware the service can provide employer mediation or thought that it was for people who were unemployed; on the other hand there was also a view that it was unfair to make services available only to those in work.

4.4 Perceptions of the need for rehabilitation services

Despite the fact that many GPs saw clear limitations to their own involvement in providing work rehabilitation and had little awareness of such provision in their area, thoughts about the need for specific services were not, generally, particularly well developed and the suggestion, when raised by the researchers, met with a mixed reception.

There was support, and sometimes strong support, for the idea of specialist services to add to what doctors were able to do themselves. GPs said that there was a need for support for people who cannot return to their old job, a service which acts for the employee rather than for the employer, and a service which could provide a more specialist and rounded approach:

‘I would like to feel that I could – in the same way that I can refer someone to benefits advice and the dietician and to our counsellor, that I could refer someone for some sort of vocational rehabilitation...which is not focused on an employer, or getting them back into that job specifically...We can sort out physio, we can sort out medical problems already, but when it comes to talking through careers advice and where they want to go – ...It would make me feel that actually we were providing them with much more holistic approach to their health care and without having to do it ourselves.’

GP with under eight years’ experience, practice of over five partners, urban area of high deprivation

There were various suggestions as to the type of help that would be required with suggestions for a multidisciplinary health team including physiotherapy, occupational health advice and counselling; specific counselling for workplace difficulties; mediation between employer and employee; assessment of capabilities and aptitudes; education for employers; careers advice, and retraining.

There were some, however, who doubted that specialist provision would add much, or that many patients required it or would be willing to use it. GPs here also commented on the fact that the services would need to work closely with individuals and to build up an in-depth knowledge of them to compare with the detailed knowledge that GPs have. There were doubts that government would be willing to fund what was seen as a very expensive service, and concerns that a government-run service might involve coercing people to return to work. For some doctors, it was clear that finding out about or using such a service would not be a priority and that it would remain peripheral to what they saw as their role.
Both positive and more sceptical reactions to the idea of specialist vocational rehabilitation services were found among the doctors who were most active in work rehabilitation. Although some welcomed the idea or had referred people to JRRP services, there was some doubt about whether they would add much to an active GP approach. Similarly, both responses were found among those who were least active. Some saw such services as useful since they covered work which GPs did not see as their responsibility, but others saw engaging with such services as outside the GP role. Among the middle group who engaged to some extent in return to work issues, reactions were positive.

4.5 Chapter summary

GPs refer patients on certified sickness absence to a range of health care professionals, both within their practices and within the NHS more widely. However, it is rare for these referrals to be motivated by work considerations (although the anticipated beneficial clinical outcome will clearly facilitate a return to work) and work issues are not significant in any communication between professionals.

There is very limited awareness of the potential role of Jobcentre Plus services such as Access to Work for people who are off sick from work but not unemployed, and very little evidence of direct contact with Jobcentre Plus, although some GPs encourage patients to go to Jobcentres if they need to consider a new job direction. There is a widespread assumption that services are available only for people who are unemployed. There is also very little awareness of specialist vocational rehabilitation services beyond JRRP services, although there are some mentions of services for people who are long-term unemployed. Some GPs were aware of JRRP, although none knew of it being used by many patients. There were some areas of misunderstanding, but also some positive responses to the concept based on feedback from patients.

Despite the view that the scope for GP involvement in vocational rehabilitation is, to varying degrees, limited, there was not always strong support for the idea of specialist provision. Some welcomed the idea and identified elements that would be useful, which largely mirror JRRP provision, but there was some scepticism as to what could, or would, be provided.
5 Conclusions and discussion

GPs’ consultations with patients on certified sickness absence clearly do involve discussions of work; indeed it is hard to see how the topic could be avoided altogether. But it is also clear that there are different approaches to managing sickness absence among GPs, and different degrees to which GPs engage with return-to-work issues. Although work is often seen as an intrinsic part of the patient’s recovery, it is not itself always a focus of GPs’ interventions.

The most active approaches are associated with a clear view that encouraging and facilitating patients’ returns to work is part of the GP remit, and that this is consistent with GPs’ obligations to, and professional relationships with, patients. There is some evidence that recency of GP training is influential, and a very tentative suggestion in the data that occupational health expertise and working in a small practice may also be relevant. Where GPs are less active in managing sickness absence, there is doubt about how far this should be part of the GP role or a clear view that it should not be. Here, attitudes and approaches are underpinned by concern about whether work is necessarily in the patient’s interests, and, more importantly, by caution about how far promoting work is possible within a constructive doctor-patient relationship. Time constraints, lack of obvious funding for work rehabilitation and limited occupational health knowledge are relevant here, and doctors are also concerned about providing equal access to treatment, irrespective of working status.

These various considerations suggest a range of possible policy options if GPs are to be encouraged to place more emphasis on work rehabilitation.

First, although there is a widespread view that work is of therapeutic value to people, there is some scope to reinforce this. In particular, there may be scope to promote information about how work can aid physical and psychological recovery, and it may also be useful to raise awareness about the financial support available to patients in low paid jobs.
What appears to be more important, however, is addressing assumptions about how far work can be promoted within a constructive doctor-patient relationship. Two possible approaches suggest themselves. One would be to support GPs’ negotiating skills and to provide education about strategies for addressing work which challenge patients’ assumptions constructively but which do not undermine the doctor-patient relationship. The other would be to introduce a more structured approach to GP consultations which involve sickness certification, requiring evidence that issues such as the remaining obstacles to work, the scope for a phased return and the likely timescale of a return have been addressed. It is likely that the former approach would be more acceptable to GPs.

Second, there is clearly scope for increased occupational health training to support GPs’ assessments of fitness for work, their understanding of the interaction between occupations and health conditions, and their ability to provide advice on whether and when to return to work and on alternative career direction. A more radical approach would be to make such training a requirement for GPs to carry out sickness certification. There may also be value in emphasising the contribution different clinical approaches can make to helping patients to return to work, within the principle of equal access to NHS treatment, and stimulating a stronger return to work focus in GPs’ clinical treatments and referrals. GPs sometimes appear to work without strong links with other clinicians and professionals, either inside or outside the practice team. There appears to be scope to emphasise the role of other professionals, and the value of more extensive communication with them about rehabilitation and return-to-work issues.

There appears to be scope for more consistency across the GPs in practice teams. It may be worth investigating whether an individual GP could provide a clinical lead within a practice, and whether case note systems could be used more proactively to underpin a more streamlined approach if a patient is likely to see more than one GP.

Sickness certification and work rehabilitation are not, however, seen as well resourced aspects of GPs’ work, in terms of the time available for it and its prominence in GP contracts. This suggests that there may be scope for funding incentives to encourage more work in managing sickness absence. It is clear that addressing returns to work requires very careful, detailed, iterative ‘psychological’ work on the part of the GPs, particularly in cases involving more complex issues.

The range of factors which act as obstacles to GPs in carrying out sickness certification, the obduracy of these factors and the strength of feelings of some GPs, inevitably raises the more radical question of whether sickness certification and the management of early sickness absence should be removed from GPs altogether and made the work of a specialist agency or other healthcare professionals. Although this would meet with support from some of those GPs who are least active in addressing work issues, it would not be consistent with the holistic model of health adopted by others and may not be feasible or practical. A possible role for other healthcare professionals is the subject of more detailed research being conducted for the DWP in the forthcoming publication of ‘The potential for certification of
incapacity for work by non-medical healthcare professionals’. An alternative approach would be to allow GPs to opt in or out of sickness certification and absence management, although this too may not be feasible and clearly would not be consistent with holistic models of primary healthcare.

There is mixed evidence about how closely GPs work with employers, and there are clearly reservations about this aspect of sickness absence management. This could be tackled in a number of ways. Promoting effective strategies and examples of good practice might support GPs in finding approaches which are consistent with protecting the interests of patients. Joint communication and training sessions with GPs and employers might help to develop more understanding of each other’s roles. GPs’ approaches are to some extent rooted in experiences of poor employer practice. This suggests that improving employer practice may be an important element of encouraging a more work-focused approach among GPs. There also appears to be more scope for sickness certification documentation to be used more actively or consistently to make recommendations to employers about how returns to work can be facilitated, by using the ‘notes’ space or other parts of the form to indicate the support or structure that would facilitate a return now.

Given the diversity in GPs’ approaches and the constraints on their active management of sickness absence, there does appear to be a role for specialist work rehabilitation services. This endorses the value of the JRRP pilot. There appears to be scope to add to what GPs provide, particularly in relation to assessments of capability and the occupational implications of conditions; advice about graded returns and alternative job routes; mediation between employers and employees; faster access to specialist clinical help, and a more work rehabilitation focus to specialist health care.

What is also promising is the fact that such services received some support among GPs who adopted different approaches to sickness absence management. Among those who are most active, it is seen as providing additional support. Among those who are somewhat cautious, it may help to ease the possible conflict between addressing work issues and preserving the doctor-patient relationship. Among GPs who are least active, it addresses a need which they see as beyond the scope of the GP remit.

However, the case for specialist provision will need to be made persuasively. Despite some doubt about employers’ motivations and practices, and despite either not seeing return to work support as in their remit or being critical of what they can provide themselves, the idea of specialist vocational rehabilitation services met with mixed responses among GPs. There are also concerns about ensuring equality of access to treatment. Thus, although the scope for more specialist provision is clear, so too is the scale of the task faced in bringing it to the attention of GPs, helping them to understand how they can make use of it for the benefit of their patients, and encouraging them to do so.
Promoting such services to GPs has been found by the JRRP services to be very time-consuming, and the fact that there was fairly limited awareness of JRRP services perhaps reinforces this. This suggests that more centralised and better funded information campaigns would be required. There is also scope for providing more information about such specialist occupational health services as do currently exist and stimulating their use. This is likely to require repeated communication, stressing how GPs can use such services for the benefit of their patients and with positive effects on their own caseloads and case management.

What is also striking is the distance between GPs and the DWP or Jobcentre Plus. This is despite a number of communication initiatives in recent months, and developments such as the Incapacity Benefit pilots which operate in part of the geographical coverage of this study. Clearly, the very time pressured nature of GPs' working lives and their mixed views about the extent to which work issues are part of their remit are difficulties here. However, there appears to be scope for raising awareness about the role of Jobcentre Plus, both in providing in-work support and advice, and in providing training and job-search support where a return to the patient's previous job is not feasible.

Finally, the findings from the study echo those of other research looking at GPs' approaches to sickness certification. The recurrence is striking and reinforces how difficult the issues are to address. This, and the range of attitudes and practices described, suggests that a number of different initiatives will be required if GPs are to become more engaged with work rehabilitation.
Appendix A
Methodology

This appendix provides further information about the conduct of the research, and copies of key study documents.

1 Sampling

The sample frame was provided by a private publishing company which specialises in providing health and care information, including the Binleys Database of GPs Practices (www.binleys.com). This is a database of over 10,000 GP practices which provides full contact details, patient list size, number of partners, name of partnership, name of practice manager and/or senior partner, and details about other specialist clinics or practitioners attached to the practice.

The research team provided postcode definitions of the four study areas and requested a random sample of 150 GP practices for each, or all listed practices in the case of Tyneside and Teeside. This was provided in Excel format. To this spreadsheet the research team added information about deprivation level and population density. Deprivation level was ascertained using an index of multiple deprivation: the Index of Multiple Deprivation 2000 for areas in England and the Scottish Index of Multiple Deprivation 2003 for areas in Scotland. (These were the most current versions available at the time of fieldwork.) Both are weighted indices which cover six domains: income; employment; health deprivation and disability; education, skills and training; housing, and geographic access to services. The indices and further information about them can be found at http://neighbourhood.statistics.gov.uk (for the England IMD) and http://www.sns.gov.uk (for the Scottish IMD).

The indices provide information at ward level. Wards were ranked and the lists divided into tertiles labelled as ‘least deprived third’, ‘middle third’ and ‘most deprived third’. These labels were then mapped on to the spreadsheet of GP practices.
The spreadsheet was then reordered by level of deprivation and, within this, size of GP practice and population density. The research team then identified a set of sub-areas within each area which provided a good spread of the key sample criteria (deprivation level, population density and size of GP practice) to enable fieldwork to be conducted efficiently. An initial sample of 27 practices per area was selected within these areas.

In selecting the sample, the research team had to attend to two further considerations. First, in two of the study areas, the Incapacity Benefit Reforms or Pathway pilots are also operating. Here, Jobcentre Plus Personal Advisers conduct regular work-focused interviews with people on Incapacity Benefit and have a range of options, including health care, on which they can draw to provide support for people who want to move into work. Since it was thought this might have led to different approaches among GPs, or different interactions with Jobcentre Plus staff, where possible practices were selected which were located in Pathways areas. In practice, however, there was no evidence in the interviews of the pilots influencing the approaches of GPs in these areas.

Second, a separate study involving fieldwork among GPs was being conducted on behalf of the DWP in one of the study areas. The DWP provided the research team with information about the GP practices which had been approached to participate in that study, and they were excluded from the potential sample to avoid overloading individual GP practices.

2 Approach to potential participants

A letter was sent to both the practice manager and the senior partner at the selected practices inviting them to participate in the study. The letters (reproduced later) indicated that the research team would shortly be approaching the practice, but a period of a fortnight was allowed for practices to opt-out if they did not want to be approached. A total of five practices opted out. The letters were then followed up by telephone calls. As noted in Chapter 1, a total of 138 letters were followed up. In some cases, the initial letter had gone astray within the practice and a copy was sent.

The main reason for practices not participating was work pressures, and some referred to it being a particularly busy period because GPs were running additional flu jab clinics. Some practices reported that they were not taking part in any research at least for the time being; others that the study was not seen as a priority or was not of particular interest to any of the GPs. In total, over 300 individual telephone calls were logged on the research team’s contact logs (likely to under-represent the total number of calls made). Practices’ switchboards were frequently engaged; the contact person not available, or, at different times of the day, the switchboard was closed and calls were not being taken.

As noted in Chapter 1, an honorarium of £75 was offered to encourage GPs to participate. Some practice managers or GPs specifically asked whether there would be a payment when approached by the research team, which suggests that at least in some cases, the honorarium was important in encouraging participation.
3 Fieldwork

Fieldwork was conducted between early October and early December 2004. Hour-long appointments were requested which meant that interviews typically lasted around 45 – 50 minutes. The interviews were conducted using a topic guide which had been developed by the research team in consultation with the DWP. This listed the issues and sub-topics to be explored, without prescribing question wording or order. Small changes were made to the topic guide as fieldwork progressed, and the final version is reproduced later.

Interviews were tape-recorded, with participants’ permission. No reference was made to the intention to tape-record in the advance letter. This is the usual practice of the research team involved, reflecting their experience that it is difficult to give a full explanation of the reasons for tape-recording in an advance letter. In the interview setting, it is more feasible to explain that the interview will not involve a questionnaire but a discussion of key topics, referring to, or showing, the topic guide, if necessary, to reinforce this; that tape-recording will allow the researcher to devote their attention to listening to the participant, reflecting on what they have to say and deciding what further questions to ask; that it would be impossible to capture the detail of the participant’s response through a written note; that the details given and the language used are important aspects of the data; that the detailed analysis will be based on the full transcript; and that the tape and transcript remain confidential to the research team and will be destroyed after a fixed period. Explaining this in the interview setting also means that any questions or concerns can be addressed.

In the experience of the research team, it is highly unusual for research participants to object to tape-recording once this is explained. In this study, however, at an early stage in fieldwork, one GP refused to take part in a tape-recorded interview (and the interview was, therefore, not conducted) and another agreed to participate only if a written undertaking about the use of the transcript was given by the researcher before the interview started. (This written undertaking was given and the interview took place.) For the remaining fieldwork, the research team, therefore, gave GPs, at the interview appointment but before the interview began, a written form outlining how the transcript would be used and indicating the GP’s consent to tape-recording, to be signed by both GP and researcher. Some GPs signed this without comment; others were surprised that written consent to tape-recording was being sought; but in a few cases, the initial reaction of the GP suggested that the form had been important in gaining their consent to tape-recording. The form is reproduced later.
4 Analysis

The data was analysed using Framework (Spencer et al., 2003) which is a matrix-based method for analysing data and involves summarising data under key themes. (A fuller explanation is given in Chapter 1.) The thematic charts used in this study covered the following themes:

Chart 1:
- Details of GP and practice.
- Local area/levels of unemployment.
- Patient caseloads, levels of sickness absence.
- Characteristics of patients on sickness absence, types of conditions.
- Any standard practices for treatment of particular conditions.
- Other.

Chart 2:
- GPs views about benefit system and sickness certification.
- Medical rehabilitation compared with work rehabilitation.
- Views about therapeutic benefits of work.
- Discussion of ways to help patients return to work.
- Any differences in approach between patient in work/out of work.
- Other.

Chart 3:
- Awareness/knowledge about patients’ work.
- Awareness/knowledge about work-related reasons for absence.
- Awareness/knowledge about non work-related reasons for absence.
- Approach to management of sickness absence.
- Negotiation process with patient, substance of consultation.
- Changing approach over course of absence.
- Patient reactions.
- Other.
Chart 4:
- Involvement of other health care professionals.
- Working with Jobcentre Plus.
- OH services: knowledge and use.
- Other services: knowledge and use.
- Contact with employers.
- Views on employer approaches.
- Views on communication with employers.
- Other.

Chart 5:
- Familiarity with term ‘vocational rehabilitation’.
- Views about key features of VR practice.
- Views about key features of effective return to work practice.
- Perceived gaps in service provision.
- Suggestions for improving current service provision.
- Researcher’s observations.
- Other.

5 Use of quotations

Finally, the report used verbatim extracts of data taken from the transcripts. The intention in using quotations has been to convey to the reader something of the flavour of the primary data and how GPs constructed their accounts. Quotations are used to illustrate the way in which GPs articulated the points highlighted in the analysis, to convey the language they used, the emphasis and strength of feeling. In selecting individual quotations, the researchers reviewed a selection of transcripts in which the relevant point was made and selected the one which best illustrated the point, avoiding extracts which, taken out of context, might misrepresent the content or tenor of the interview. The research team monitored the selection of quotations to avoid over-reliance on individual participants and to ensure that the voices of all participants were represented. At least one and no more than three quotations are used from each GP (except in the case of two interviews where tape-recording failed: in both cases, detailed notes were made by the researcher immediately after the interview but no quotations could be used.)
Appendix B
Letters
Advance letter sent to practice managers

Insert date

Dear

Research into GP approaches to working with patients on sickness absence

We are writing to ask for the help of your practice with a research study focusing on the way GPs work with patients who are on certified sick leave. The Department for Work and Pensions (DWP) and the Department of Health (DH) have commissioned this project as part of a wider programme of research investigating effective ways of helping people to seek or return to work after a period of sickness absence: an area which is becoming an increasingly important focus of government policy. GPs are key stakeholders in the process of working with these patients. It is important to explore with GPs not only the ways in which they and other health care professionals are currently working with patients, but also their views on the scope of their role and key challenges they face.

The National Centre for Social Research (NatCen) and the Social Policy Research Unit (SPRU) at the University of York – both independent research organisations – have been commissioned to carry out interviews with selected GPs. A researcher from [the National Centre for Social Research/Social Policy Research Unit delete as appropriate] will contact you shortly to talk to you about the possibility of you or one of the GPs at your practice contributing to this study.

The research is entirely confidential. Answers are treated in strict confidence according to the Data Protection Act, and we will not name any individual GP or practice in the research reports. The interview will last approximately 45 – 60 minutes, and each GP will be paid an honorarium of £75 in appreciation of the time given. Participation is voluntary and the researcher can arrange the interview for a time and place convenient for the GP.

If none of the GPs at your practice are able to take part in the study, please contact me on the above contact details. For further information or any queries about the research please contact either me at NatCen or Leah Harris in the Social Research Division of DWP on 0207 712 2327; or by email: Leah.Harris@dwp.gsi.gov.uk.

We hope that your practice will be able to take part in this study. Your contribution would be greatly valued.

Yours sincerely
Advance letter sent to senior partner


ing date

Dear Dr

Research into GP approaches to working with patients on sickness absence

I am writing to you because we have written to your Practice Manager about a research study focusing on the way GPs work with patients who are on certified sick leave. The National Centre for Social Research and the Social Policy Research Unit, both independent research organisations, have been commissioned by the Department for Work and Pensions (DWP) and the Department of Health (DH) to carry out this project. Please find a copy of the letter we sent to your practice manager attached. We will liaise with them to discuss the possibility of you or one of your colleagues taking part in this study.

If you would like any further information or have any queries about the research please contact either me on the contact details above, or Leah Harris in the Social Research Division of DWP on 0207 712 2327; or by email: Leah.Harris@dwp.gsi.gov.uk.

Otherwise, we will be in touch with your practice and very much hope that you or one of your colleagues will be able to participate in this research.

Yours sincerely,
Form for consent to tape-recording

Research into GP approaches to working with patients on sickness absence

Consent to tape-recording

I confirm that:

• the interview has been tape-recorded to provide a full and accurate record of the discussion;

• the tape will be transcribed and the research team will work from the transcription in carrying out their analysis;

• the tape and transcript will be used only for the purposes of this research study and not for any other purpose;

• the tape and transcript will be kept securely and destroyed 12 months after the completion of the research study.

......................................................... ....................................................

Insert name of researcher               Date

I consent to the tape being used for these purposes only:

......................................................... ....................................................

Insert name of GP                       Date
Appendix C
Topic guide
Final version of topic guide

P6114 JRRP: 1st focused GP study

Exploring attitudes and experiences of vocational rehabilitation

Final topic guide 11.10.04

Aims and objectives

• Explore how GPs work with patients who are on sickness absence; any differences in practice between patients in work or out of work; extent to which GPs engage with the political agenda ‘work is good for you’.

• Discuss understanding of the term vocational rehabilitation and any GP experiences of VR.

• Understand the way in which GPs work with other health care professionals around VR, including the referrals process, ongoing communication about patients and problems and difficulties.

• Investigate with GPs whether they use any VR/occupational health services and gain an understanding of their experiences and ideas about what services would be most useful to them and their patients.

• Explore the nature of any contact with employers regarding patients on sickness absence, what communication takes place and GP perceptions of the value of this relationship.

Introduction

• Introduce self and research organisations involved (NatCen, SPRU).

• Research study commissioned by DWP and DH as part of wider programme of research looking at provision of support to people who are off sick from work, emphasise our independence from government.

• Focus of interview on how GPs work with patients who are on certified sick leave (those both in and out of work but emphasis is on those who have a job to return to), scope of the GP role in rehabilitation of these patients, role of other health care professionals, occupational health and other service provision in supporting these patients.

• Interview expected to last between 45 – 60 minutes, participation is voluntary, interviews are confidential, £75 honorarium payment.

• Explain about tape recording of interview.

• Any questions.
1. **Background**  
*(collect factual information from practice manager if possible either before or after interview)*

- Background information about respondent: length of time as GP, in current GP practice, any clinical specialisms or areas of interest.
- Information about GP practice: total number of GPs, how many partners, any locums; whether patients will generally see the same GP; any clinics or other health care professionals based at the practice.
- Background about patient caseload and local area: nature of local labour market, size of caseload, levels of unemployment amongst patient caseload.

2. **Working with patients who are on certified sick leave**

- (Briefly as contextual background) explore levels of sickness absence across patient caseload and characteristics of patients on certified sick leave:
  - most common conditions amongst this group;
  - explore whether absences tend to be long-term, short-term or repeated, any differences by condition.

- Explore scope of GP’s role in working with patients on sickness absence, their desired outcome – medical rehabilitation and/or rehabilitating patient so they are able to work *(remind that we’re talking about patients on certified sickness absence with a job to return to)*:
  - is there a meaningful difference in practice?
  - how far is clinical input oriented to return to work vs medical rehabilitation?
  - difference in level of recovery required for medical/work rehabilitation;
  - any difference in aims/role depending on whether patient has / hasn’t got job open to them, or is/isn’t keen to return to work, or other factors?
  - can they imagine a GP role which sees return to work as its main aim, would this involve anything different to their current practice?

- Explore GP views of the idea that ‘work is good for you’, ie of therapeutic value:
  - extent to which they agree with this and circumstances where they think it is/isn’t true (eg medical condition, social circumstances, work circumstances);
  - how well evidenced is this view?

- Explore how much GP would know about or discuss with patient (both when do initial certification and in on-going contact with patient):
  - the nature of a patient’s work;
  - work-related reasons for absence;
  - other factors accounting for absence.
• Discussing work with patients:
  
  Aim is to explore:
  
  a) level of detail of discussion about patients’ work/reasons for inability to return to work;
  b) extent to which GP actively manages returns to work.

• – when and how do they raise issue of work;
  – response if client seems reluctant to return to work for non-medical reasons [where are/aren’t broader psycho-social reasons];
  – discussion/negotiation of time scale, duration of sickness certificates;
  – discussion of steps involved in return to work, any planning;
  – discussion of scope for reduced duties/hours;
  – discussion of work options/considerations whether patient is unable to return to old job.

• How patients respond, any difficulties:
  – any differences by condition, motivation, work/social circumstances etc?
  – any barriers to/difficulties with addressing it in way GPs prefer to?
  – does GP approach change over course of patient’s illness?
  – approach with patients who are repeatedly off sick.

• Explore any differences in practice between patients who are in work/out of work.

• Whether their views and practice have changed over time.

3. Understanding of vocational rehabilitation

• Investigate GP understanding of the term vocational rehabilitation: find out whether it is a term they are familiar with.
  – establish respondent’s view of the key features of effective VR practice as they see it (eg timing, specialisms, breadth of focus);
  – explore GP knowledge of current VR practice;
  – what source(s) of information have informed their view?

• if not:
  – explore what they understand by the term, provide overview of VR (see DWP paper VR: a working description: definitions vary but broadly involves process of getting people who have been sick/injured back to work;
  – any tensions between the objectives of their role compared with that of VR/how far see VR as part of GP remit.
4. Working with other health care professionals/service providers

- Find out what services GP uses specifically to aid return to work (prompt for health care professionals, specialist and private VR/OH services, NHS Plus, employer occupational health schemes and Jobcentre Plus if necessary. If Jobcentre Plus mentioned, try to distinguish between IB Pilot and other services in relevant areas).

- If do not use, explore why not (eg not seen as necessary/useful, not aware of services, poor experiences of using).

- Where services used, in relation to each explore:
  - **aims**: how explicit is return to work as GP aim in using service with patients and other health care professionals;
  - **referrals process**: length of waiting lists, any impact on patient’s ability to return to work;
  - **cost** of buying in services;
  - **communication**: who has responsibility for case management, sharing information – with whom, methods of communication used and preferred, frequency of communication desired and in practice;
  - **effectiveness of intervention** in enabling patients to return to work: what works well/less well, barriers to effectiveness (for different types of intervention and patients) suggestions for improvements;
  - **example** from caseload of patient who has and has not returned to work through such an intervention: what helped/hindered process.

Ensure coverage of health service, specialist VR/OH and Jobcentre Plus

- Any other services known about but not used by GP?
- Any gaps in service provision?
- Explore mechanisms in place for ensuring services meet individual’s needs.
5.  **Liaising with employers**
- Explore GP experiences of working with employers in the management of the condition of employee’s on sickness absence from work:
  - do they view communication with employers as part of their role as GP?
  - how common, under what circumstances?
  - aims and desired relationship;
  - nature of communication: who initiated contact, who was contact with at employer, frequency, content, preferred mode of communication;
  - GP views of usefulness of contact with employers in rehabilitation of patients: what works well/less well;
  - GP views on different attitudes of employers in managing sickness absence and impact on their work with the patient;
  - GP awareness of follow up support/assessments for patients after they return to work, additional support;
  - suggestions for the future (need for additional support).

6.  **Conclusion**
- Key features of effective practice (by GPs and if appropriate other service providers) in helping clients return to work.
- Anything that would help clients to return faster/more effectively?
- Any need for additional services?
- Any other thoughts or comments?

Thank GP for participating in research, reassure about confidentiality, pay £75.
References


