The role of GPs in sickness certification

Julia Hiscock and Jane Ritchie
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SUMMARY

Introduction to the research
GPs are required to provide medical statements recording the advice which they give to patients regarding their ability to perform their own or usual type of occupation. These medical statements form part of the system through which people assessed as incapable of work through disease or disablement receive Statutory Sick Pay (SSP) or a state incapacity benefit such as Incapacity Benefit (IB). The purpose of this study was to explore GPs’ views about their role in sickness certification.

The study used qualitative methods. In-depth interviews with 33 GPs were conducted. In addition, towards the end of the study, five small discussion groups were held to explore possible solutions to the problems which had been identified in the in-depth interviews. A literature review was also conducted.

Literature review
The literature highlights a range of financial, personal and workplace factors which shape people’s sickness absence habits (see Chapter 2). It also identifies characteristics of GPs and of patients which may influence GPs in their sickness certification behaviour (see Section 2.2). Patient characteristics such as age, attitude and job prospects were reported to be a very major influence on the way that GPs approach sickness certification. GP characteristics, such as the level of training, the extent of involvement in occupational health and GP age were also reported to have an impact on both approach to and rates of certification.

There is some discussion in the literature of conflicts of loyalty created for GPs by their role in sickness certification and concerns about its impact on the GP-patient relationship (see Section 2.3). There is also discussion of the fact that people who take extended periods of sickness absence may be in danger of falling into the ‘sick role’ which is accompanied by sickness behaviour, legitimised by a medical certificate, and which makes a return to work more difficult. The literature reveals some parallels between sickness certification and prescribing, in for example, the impact of the GP-patient relationship and of patient expectations.

Judging incapacity for work
Three main perspectives were expressed when GPs were reflecting more generally on their role in sickness certification (see Section 3.1). First, there are some GPs who would very much prefer to have no role in certification at all. Secondly, there is a group of GPs who think that responsibility for sickness certification sits rightfully with the GP, but feel that some modifications to the role would be beneficial. Lastly, there is a third group of GPs who value their participation in sickness certification and feel that GPs are best placed to play this role.
When GPs issue medical statements to their patients, they are required to base their certification judgements on the patient’s medical condition and resultant functional limitations. However, interviews with GPs revealed that in practice the process adopted is actually more complex and often more multi-dimensional than the official guidance, which is based on the relevant law, requires (see Chapter 3).

For some GPs, the process of judging whether a patient is fit for work may be smooth, simple and straightforward. However, more often it is a highly complex process, involving reconsideration, uncertainty, and a number of stages and types of deliberation. There are many interrelated factors which influence the way in which the process of judging incapacity takes place (see Section 3.3). Patient behaviour, busy surgeries or inadequate consultation times, for example, can result in some GPs feeling that it is often easier to ‘just sign’ than to engage in a lengthy discussion. The GP-patient relationship is a crucial consideration and will very often influence their certification practice, as will how well the GP knows the patient, as GPs often found it easier to negotiate an alternative to certification with patients they know well.

GPs are required by law to provide medical statements to their patients regarding the advice they have given regarding the patients’ ability to perform their own or usual type of occupation. By law this advice can only relate to incapacity arising from the medical disease or disablement. In practice, however, there are differences in the ways in which GPs make decisions about certification (see Sections 3.2–3.4). Several approaches are identified in the report, only one of which strictly accords with the official guidance which is based upon the relevant law. In practice these approaches are positions on a continuum, rather than being discrete categories, since GPs acknowledge that their approach will change over time. The approach which does accord with legal requirements is found in GPs who try very hard to limit their assessment of incapacity solely to the patient’s condition and the demands of the type of work that they do. Another approach occurs where GPs’ assessment is also heavily derived from the patient’s condition and occupation, but a very limited number of other factors may also be taken into account. A third group is GPs who acknowledge that they take into account multiple factors and influences. Although not in accordance with the legal requirement, certificates are often issued, for example, for people who are caring for sick relatives or children.

Many GPs experience a number of difficulties in judging capacity for employment (see Section 3.5). Assessing the medical condition, particularly in the case of subjective or difficult to measure conditions such as back pain or anxiety conditions, is particularly problematic. Other difficulties in carrying out their certification role are presented by patient expectations, the GP-patient relationship and having little or no access to specialist occupational advice.
Managing the return to work

GPs perceived a number of barriers to their patients’ return to work (see Chapter 4). These included patient factors such as: age, personal attitudes, expectations, attitude to work and/or job satisfaction; factors relating to the patients’ employment including: situations where patients’ work was linked to the onset of their condition, where prolonged absence had led to the adoption of the sick role, where their condition dictates a need to change type of occupation, or where the employer could not offer flexibility or a gradual re-introduction to work. Three main GP approaches to managing the return to work can be identified. These can be characterised as: a ‘firm negotiator’; a ‘soft negotiator’ and ‘non-interventionist’ (more detail can be found in Section 4.1).

The GPs’ choice of timing to raise the issue of the return to work or to job seeking varies considerably (see Section 4.2). Influenced by the patient’s motivation, employment circumstances or condition, or by their own personal approach, the GP may decide to raise it: at the commencement of certification; after a set period of time; when the condition is obviously improving; when the patient has completely recovered and/or when initiated by triggers or milestones.

There was some difference in the approach which GPs take to patients who are employed as opposed to those who are not. GPs described how a high proportion of patients who have jobs are keen, for financial or other reasons, to return to work as soon as they are well (or earlier) (see Section 4.3). The example of patients who were self-employed was often cited here. GPs found more difficulty in encouraging a return to work if patients were unhappy in their jobs or if there had been a link between their work and the onset of their illness. A return to work was seen to be facilitated by employers who would allow a gradual or flexible re-introduction to work.

GPs find it more difficult to manage their patients’ return to job seeking and unemployment than the return to a job (see Section 4.4). GPs were often influenced by their perception that their patients would be in a worse financial situation on JSA, as opposed to IB. In cases where GPs felt that their patient’s job prospects were low, they were often loath to commit them to what they felt was likely to be an unrewarding job search.

Providing medical evidence

There was a general aversion to, and some confusion about, the forms, which GPs are required to fill in relating to sickness certification (see Section 5.1). This was combined with a lack of knowledge of what happens to the information which GPs supply to the BA. It was felt that systems for communication both to and from the BA could benefit from being simpler, clearer and more explicit.
The curriculum for GP Registrar training, which ends with accreditation of ‘prescribed experience’ by the Joint Committee for Postgraduate Training in General Practice, includes certification practice. However, GPs’ education in certification practice and procedures was generally minimal and informal. It tended to consist of being taken through the various certificates and forms by a GP trainer or one of the senior partners as a GP registrar (see Section 5.6). *The Guide for Registered Medical Practitioners, IB204* (DSS, 2000) was found useful by those who had read it, although the desk aid flow chart was more favourably received (see Section 5.4). Lack of time, inclination or awareness meant that it was rare for GPs to seek advice from Medical Services, and there were mixed views about whether more or improved contact was desirable. Contact with patients’ employers was similarly limited, and was usually initiated by the employer. GPs’ views were divided about the value of further contact, some were concerned about confidentiality or the GP’s role, whereas others saw contact with patients’ employers as very beneficial for a well-planned return to work (see Section 5.5).

The most recurrent and widely supported solution offered during the research was for greater help for GPs with assessing incapacity¹ and helping patients to optimise their employment or rehabilitation potential. A suggestion was made to establish an occupational health resource, to which GPs can easily refer certain patients at a reasonably early stage of their sickness absence according to respondents (see Section 6.1). Such an occupational health resource should be able to: assess the patient’s condition in order to provide a second opinion on the nature and level of incapacity; provide occupational health advice about the nature of work that could safely be undertaken with the patient’s condition; provide advice where needed, about any adaptations that might need to be made to the workplace or conditions of employment; provide advice on opportunities for employment rehabilitation where required.

There was a related call for more employment-based occupational health services, including a suggestion for more widespread occupational health services which smaller employers could buy into. It was also felt that there should be easier to use mechanisms for GPs to flag to employers that a return to work could occur quite soon if some form of phased or ‘gentle’ re-entry could be arranged.²

A number of suggestions were made by GPs relating to the more practical aspects of the certification procedures (see Section 6.2). There was conflicting evidence about the need for feedback from the BA. GPs were

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¹ Throughout this report, the term ‘incapacity’ is used to describe a sickness or disability that prevents individual from working.

² This facility does already exist in the notes section of the Med 3 form.
divided in their views about what information was required. One clear suggestion however, was that communication from the BA could be improved if it was brief and its relevance to the GP made immediately apparent. Although there is quite heavy resistance from GPs to more form filling than already required, there were suggestions that the Med 3 might provide a better vehicle than at present to provide information of value to employers or the BA.³

A specific suggestion that was made repeatedly was to enhance the use of the RM7. In particular, doctors requested that two further roles of the RM7 would be beneficial. The first was for some acknowledgement from the BA that the message on the RM7 had been received (even though the RM7 may have been used inappropriately in the first 6 months, when no action from the BA was required). Secondly, GPs wanted to be able to nominate some intervention that would lead to the patient concerned being called in for an independent assessment, for example by medical services doctors, of capacity for employment.⁴ For some GPs, the need for such assessment was closely linked with some rehabilitation opportunity, however others were more concerned about setting up a better monitoring system to stop unnecessary claims for SSP and state incapacity benefits although they did not want to have to ‘police’ the system themselves.

Despite the fact that advice on fitness for work and certification forms part of the clinical management of many patients this was not seen as a particularly appealing subject for GP training, and there was little enthusiasm for boosting certification in the formal part of GP postgraduate training. However, there were suggestions that certification could be a unit within personal training plans or that greater use could be made of articles in periodicals to discuss and inform GPs about sickness certification.

³ The Med 3 form can already be used in this way.

⁴ The facility for both of these things which GPs wanted does exist. There is a system in place within the BA to acknowledge receipt of an RM7 where no action can be taken. GPs can also highlight cases they are unsure about to the BA for further investigation. However, the GPs reporting this in interviews were unaware that these systems existed and perceived a need for them.
This study explores the role of GPs in providing medical evidence about incapacity for work. It has been funded by the Department for Work and Pensions to inform policy design and guidance and training for GPs.

This study is concerned with GPs’ role in certification for Statutory Sick Pay (SSP) and Incapacity Benefit (IB). Introduced in April 1995, IB replaced Invalidity Benefit (IVB) as the main long-term state contributory benefit paid to people who are assessed as being incapable of work because of disease, or bodily or mental disablement. Since Incapacity Benefit was introduced, judgements about longer-term entitlement to incapacity benefits have become the responsibility of the Benefits Agency.

There are two other state incapacity benefits, which are paid to people who are unable to work due to their medical condition or disability. Firstly, there is a non-contributory disability premium, which is paid to people who receive Income Support. Secondly, people who are unable to work because of their medical condition or disability can be credited with National Insurance credits, which will help to protect their eligibility to future state benefits, such as the state retirement pension.

In order to be eligible for the state benefits described above, claimants are assessed in order to determine whether they are incapable of work. There are two tests of incapacity. The first is the Own Occupation Test, which is applicable for the first 28 weeks of incapacity, and which tests whether the claimant is incapable of the work normally done in the course of their own occupation. The second assessment is the Personal Capability Assessment (PCA), which is the main medical assessment for state incapacity benefits. Introduced on the 3rd April 2000 (replacing the All Work Test), it differs from the Own Occupation Test in that it seeks to assess not whether the claimant is incapable of performing tasks relating to their occupation, but whether they are incapable of performing certain specified everyday activities relevant to work. The PCA is applied from the 29th week of a period of incapacity (or from the outset of incapacity if the claimant is not eligible for the Own Occupation Test).

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5 There has been a third benefit, the Severe Disablement Allowance, which has been paid to people who have insufficient National Insurance contributions to be eligible for IB. This benefit is to cease for new claimants in 2001, when, for young adults, it will be incorporated into IB.

6 Provided the person has been working for at least 16 hours per week, in at least 8 of the 21 weeks prior to the period of incapacity.
1.1.2 GPs’ role in medical certification

Medical statements issued by GPs provide medical evidence to support patients’ claims to Statutory Sick Pay, administered by employers, or state incapacity benefits. Thus, in relation to employers, medical statements may help in the management of the sickness absence. The Guide for Registered Medical Practitioners opens with a statement of doctors’ obligations in providing medical evidence:

‘Doctors are required to provide certain medical statements to their patients free of charge and to provide factual information, related to such statements, to a Medical Officer on request. Payment for these responsibilities is made to all NHS GPs through their fees and allowances. A doctor is required to record on a medical statement the advice given to the patient regarding their ability to perform their own or usual type of occupation’.

(Guidance for Doctors. IB204, p.4. Department of Social Security, 2000)

Prior to the introduction of IB, GPs were required to issue regular statements, judging whether their patients were fit for work and thus determining patients’ eligibility for both long and short-term state incapacity benefits. Since 1995, when IB replaced IVB, judgements about entitlement to long-term benefits have become the responsibility of the Benefits Agency (BA). GPs still play a role in this by providing factual medical evidence to inform this process (this is done on the form IB113). However, once the BA test has been applied, after 28 weeks since the onset of the period of incapacity (or earlier if the claimant has been unemployed), GPs are no longer required to supply medical certificates for their patients.

Since 1995, when Incapacity Benefit (IB) was introduced, GPs have had three major functions in providing medical evidence of incapacity for work:

- Provision of medical statements to patients who are claiming Statutory Sick Pay (SSP) or employers’ sickness benefit or state incapacity benefits before the state medical assessment (the PCA) is applied.
- Statements to patients detailing the diagnoses and their disabling effects at the time the PCA is applied.
- Factual reports on patients who may be exempt from the IB Personal Capability Assessment (PCA) because they are suffering from a prescribed medical condition.

This study is primarily concerned with GPs’ participation in the first of these three roles, which is required during the first 28 weeks of incapacity. This is in recognition of the crucial role which GPs play during the first 28 weeks. It is also because of a need to understand how GPs can most effectively be involved in early interventions to help patients retain, or regain, employment where appropriate, before long term sickness patterns may become established.
There are two pilot schemes, which are part of the government’s Welfare to Work initiative, which also have direct relevance for the subject of this study:

- The New Deal for Disabled People (NDDP) focuses on the provision of a Personal Adviser who offers advice and support for people who have a long term illness or disability (particularly if they are in receipt of IB) and who are interested in moving into, or remaining in, work.
- ONE aims to provide a ‘single gateway’ to state benefits for most working age claimants. A Personal Adviser is provided to offer support and guidance, for those who are interested in considering employment, training or rehabilitation.

These pilot schemes were of relevance to the research, as both NDDP and ONE are aimed at helping people on benefit or at risk of losing their work, to move into or keep their jobs. The pilot areas are testing approaches to achieving this, and provide distinct services to that end. Within this research we wanted to explore GPs’ awareness of pilot services. We therefore purposively chose to carry out some interviews with GPs in ONE/NDDP pilot areas (Section 4.4 describes GPs’ awareness of these pilot schemes).

1.2 Aims and scope of the study

The central aim of the research was to investigate the role played by GPs in the certification of sickness for benefits and their views about the activities in which this involves them. Within this broad context, the study had three distinct objectives:

- To explore how GPs currently carry out their roles as certifying medical practitioners, the help and advice they provide to patients, and their views about the current arrangements for both SSP and IB.
- To examine how GPs perceive their role in helping patients to make appropriate decisions about employment, and their views about how this fits within the range of services available to people of working age with illness or disabilities.
- To determine what help, training or guidance GPs would find helpful to carry out their current role more effectively, and their views about possible enhancements or future policy developments.

Underlying each of these objectives was a more general quest to determine how GPs can be most effectively involved in early interventions to help people retain, or regain, suitable employment where these are the appropriate actions.

1.3 Research design and conduct

The research design comprised three components:

- Desk research to review the existing literature about the role of GPs in sickness certification. This was to inform the development of the research tools and assist with the interpretation of findings.
• In-depth exploratory interviews were conducted with 33 GPs. This formed the main body of the research. In-depth interviews were used because the processes being discussed were complex and it was important that GPs had the opportunity to raise relevant issues of concern to them.

• Five small discussion groups with GPs, referred to as ‘strategic groups’, were conducted towards the end of the project. These explored ideas and issues arising from the in-depth interviews and identified possible ideas and solutions for aiding GPs in their sickness certification roles.

In addition to these elements, visits were made at the outset of the study to Medical Services Centres for discussions with Medical Services doctors, many of whom have extensive experience of general practice. This was primarily an orientation exercise, which fed into the development of areas of questioning for interviews with GPs.

1.3.1 The sample

The sample was purposively selected to ensure a range of criteria were covered including catchment area, practice type and GP characteristics. Eight geographical areas of England, Scotland and Wales were selected for the depth interviews. This included some locations where NDDP/ONE were being piloted. A further five areas were covered by the strategic groups.

The GPs for the depth interviews were selected from GP databases. For the strategic groups, postgraduate deans in each of the five areas facilitated access to local GPs. Approximately half of those attending the groups had specialist roles, such as a GP tutor or member of a Primary Care Group Board or Local Medical Council. A profile of the GPs who participated is given in Appendix A.

1.3.2 Data gathering

The depth interviews were conducted between May and August 2000, and the strategic groups were conducted in November 2000. Topic guides were used as a basis for the discussion although they were used in a flexible manner to allow GPs’ own accounts and perspectives to emerge. Copies of the topic guides are provided in Appendix C.

The duration of the depth interviews ranged from half an hour to an hour and a half, although most lasted slightly more than an hour. The strategic groups generally lasted for approximately two hours, which included a brief presentation of some summary findings of the earlier part of the study.

All the interviews and discussions were tape recorded with the GPs’ agreement. The GPs who participated were paid a small honorarium in appreciation of the time and help they gave to the study.

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1.3.3 Analysis  The depth interviews and strategic group discussions were all tape-recorded (with the permission of respondents), transcribed verbatim and analysed using ‘Framework’. Framework is a systematic and accessible approach to qualitative data analysis developed by the Qualitative Unit at the National Centre for Social Research. Using Framework facilitated analysis, both on a thematic level and on a case-by-case basis and subsequent interpretation of the data.

1.4 Coverage of the report  The interviews and discussions generated particularly rich and complex material, which this report describes and explores. Because the study was qualitative in design, this has made it possible to describe the range and nature of perspectives held by the doctors and the factors that underpin them. However, the study cannot provide any statistical data relating to prevalence of views or experiences nor does it seek to infer any general patterns relating to how GPs’ views might be distributed in the broader population.

Throughout the report, quotations and case illustrations are given to illuminate the issues discussed. Where necessary, details have been changed, to protect the anonymity of the respondents and their patients.

Chapter 2 presents the main findings from the review of the literature. Chapters 3 and 4 analyse the often complex processes in which GPs are involved when judging incapacity, or managing a return to work for their patients. Chapter 5 considers GPs’ views on the mechanisms through which they are requested to provide medical evidence. Chapter 6 explores solutions and strategies for change, emerging from the GP interviews and discussions groups and Chapter 7 concludes.
In May 2000 at the outset of this study there were 2.26 million IB claimants (including credit-only cases), in Great Britain. This is one per cent less than a year earlier, and six per cent less than when IB was introduced in April 1995 (DSS, 2000b).

The predecessor of IB was Invalidity Benefit (IVB). From 1971, when IVB was introduced, there had been a continuing increase in the number of claimants. During the 1980’s and early 1990’s the number of people receiving benefit more than doubled (Ritchie et al., 1993).

There are three rates of Incapacity Benefit. There are two short-term rates: a lower rate which is paid for the first 28 weeks of sickness where people are not on SSP and a higher rate which is paid between weeks 29 and 52. There is also a long-term rate for periods of incapacity of over one year (DSS, 2000b). The number of people claiming the short-term lower rate of Incapacity Benefit totalled 93,300 at May 2000 which is an increase of two thousand over the previous year (DSS, 2000b). The table below shows the changes in the lower rate of Incapacity Benefit since the introduction of IB in April 1995. It shows declining rates until May 1999, with an increase since then:

<table>
<thead>
<tr>
<th>Year</th>
<th>May 95</th>
<th>May 96</th>
<th>May 97</th>
<th>May 98</th>
<th>May 99</th>
<th>May 00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of short-term lower rate IB claimants (thousands)</td>
<td>128.1</td>
<td>121.1</td>
<td>117.6</td>
<td>103.8</td>
<td>91.6</td>
<td>93.3</td>
</tr>
</tbody>
</table>


A UK study found the average level of sickness absence to be 4.1 per cent of working time, and that the average British person takes seven days off sick per annum (MacErlean, 2000). The most commonly used measurement of sickness absence in general practice is the number of sickness certificates per 100 encounters. These rates show a significant variation in different studies, ranging from 11 per cent to 35 per cent. However, differences may be at least partially accounted for by differences in morbidity patterns (Tellnes, 1989). Luz and Green (1997) stated that internationally ‘genuine’ sick leave, depending on the country and circumstances, amounts to approximately 60 per cent–70 per cent of absence from work. A study by the Institute of Personnel and Development (2000) indicated that in the UK, more than a third of sickness absence days are unrelated to ill health, with the average worker taking three non-leave days off a year when they are not unwell.
According to studies from various countries, short-term episodes of sickness certification are most likely to begin on Mondays, or the early days of the week, and to end on Fridays (Lunn et al., 1970; Rutle, 1983; Bellaby, 1999). Seasonal differences in short-term sickness absence (Bellaby, 1999) and higher levels of sickness absence in the public rather than the private sector (MacErlean 2000) have been identified. What Luz and Green (1997) refer to as ‘healthy worker absence’ is more commonly found when an employee is in the early or late stages of their period of work with a particular employer. A survey of 182 employees in the UK, reported by MacErlean (2000) found that managers take less time off through sickness than other employees do.

A UK study by MacErlean (2000), found that women take more time off than men. However, Fournier (1989), writing about the situation in France, found that over the span of their entire professional lives, men and women take approximately the same total absence, with women taking more sick leave and personal absences and men being more absent due to accidents.

Research in Sweden found that leave granted to take care of sick children accounted for 25 per cent of all spells of absence (Luz and Green, 1997). This pattern is confirmed by Fournier (1989) who showed that women’s absences peak between the ages of 25–35 and Leigh (1991), who reported that having small children was the most important predictor of absence for women. The Employment Relations Act (1999) now makes it mandatory for employers to allow employees to take a limited amount of time off for urgent family responsibilities or ‘domestic incidents’.

In May 2000, 6.4 per cent of the working age population of Great Britain was claiming IB (all forms) (DSS, 2000b). There was some regional variation in these rates which are shown below:

<table>
<thead>
<tr>
<th>All IB as % of working age pop</th>
<th>All</th>
<th>North</th>
<th>North Yorks</th>
<th>E. Midlands</th>
<th>W.Midlands</th>
<th>South</th>
<th>East</th>
<th>London</th>
<th>South</th>
<th>England</th>
<th>Scotland</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>All IB as % of working age pop</td>
<td>6.4</td>
<td>9.9</td>
<td>9.2</td>
<td>6.6</td>
<td>5.6</td>
<td>6.2</td>
<td>4.9</td>
<td>4.0</td>
<td>5.3</td>
<td>3.5</td>
<td>5.9</td>
<td>8.9</td>
</tr>
</tbody>
</table>

The main reasons cited for sickness absence which led to the highest number of IB claims is shown below:

**Table 2.3 The five diagnoses which led to the highest number of ‘new’ claimants of IB at 31 May 2000 by diagnosis group**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>IB claimants (thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental and behavioural disorders</td>
<td>701.7</td>
</tr>
<tr>
<td>Disease of the musculoskeletal system and connective tissue</td>
<td>535.0</td>
</tr>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>275.1</td>
</tr>
<tr>
<td>Diseases of the Circulatory System</td>
<td>196.6</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>144.6</td>
</tr>
</tbody>
</table>


A higher number of men than women are IB claimants. Although the number of men claimants has decreased since 1996, the number of women claimants is increasing with the increase of women in the labour force:

**Table 2.4 IB claimants by sex**

<table>
<thead>
<tr>
<th>Year</th>
<th>May 95</th>
<th>May 96</th>
<th>May 97</th>
<th>May 98</th>
<th>May 99</th>
<th>May 00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>1,655.9</td>
<td>1,609.5</td>
<td>1,568.5</td>
<td>1,506.0</td>
<td>1,458.9</td>
<td>1,426.9</td>
</tr>
<tr>
<td>Women</td>
<td>763.8</td>
<td>787.1</td>
<td>802.0</td>
<td>811.0</td>
<td>818.6</td>
<td>836.3</td>
</tr>
</tbody>
</table>


**Figure 2.1: IB claimants by sex**

The number of IB claimants increases with age. The majority of long-term sickness benefit recipients are older people, resulting from a number of interacting factors, such as morbidity, outdated skills or long term unemployment. The 50-59 age group have the highest incidence of episodes of receipt of IB:

Table 2.5 Number of claimants of IB at 31 May 2000 by age

<table>
<thead>
<tr>
<th>Age</th>
<th>Under 20</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claimants (thousands)</td>
<td>23.3</td>
<td>77.9</td>
<td>120.9</td>
<td>174.1</td>
<td>205.1</td>
<td>229.6</td>
<td>272.9</td>
<td>384.2</td>
<td>439.6</td>
<td>334.2</td>
<td>1.2</td>
</tr>
</tbody>
</table>


Figure 2.2 Number of claimants of IB at 31 May 2000 by age


2.1.1 Factors that may influence sickness absence behaviour

A range of different factors is identified as influencing people not to take sick leave. Fear of competition or of showing weakness (Luz and Green, 1997), or a knowledge that they will be missed, for example, may discourage sickness absence (MacErlean, 2000). Other factors encouraging people to remain in work are concerns about loss of income, bonuses or overtime, or the state of the labour market (Luz and Green, 1997). However, there are also other factors, which act to positively encourage people to remain in work or to limit their period of sickness absence. These are largely emotional drivers, such as ‘dedication to task’, ‘type-A compulsive behaviour’ (Luz and Green, 1997), strong personality characteristics, people who want to work as a matter of principle or duty (Cristoph, 1974), or the protestant work ethic (Bellaby, 1999). A high level of job satisfaction, can also be a strong encouragement to remain in work (Luz and Green, 1997).

Factors that may encourage people to want to take or extend periods of sickness absence are largely workplace factors. These include poor working conditions, lack of group cohesiveness, poor quality leadership, self-perception of illness, a low priority placed on their job as opposed to on family responsibilities, or the appeal of sickness absence as a ‘refuge’ or ‘withdrawal’ from an occupational environment in which they feel unable to cope (Kung, 1975; Straw, 1977; Schokking-Siegerist, 1981; Luz and
A decision to stop work because of a chronic medical condition or disability is often made by the worker, with or without the advice or agreement of a health professional or employer. The key factors which influence this decision are the symptoms perceived (e.g. pain, disability, anxiety), the nature of the work demands and the socio-demographic context. A person is more likely to refrain from work when they fall ill when:

- there is little perceived risk of losing his or her job (e.g. because of low unemployment or skills shortage);
- there is little or no economic loss (because of continuing pay or good wage replacement rates);
- there is little disapproval from fellow workers and managers (Karasek and Theorell, 1990; Enterline, 1966; Waddell and Norlund, 2000).

Patient-related factors that may influence a GP’s judgement about capacity for work have been shown to be extensive (Ritchie et al., 1993; Tellnes, 1990). Apart from the medical condition, which is usually at the forefront, the literature indicates that the patient’s age is an important influence on the GP’s certification behaviour. In addition to age, Ritchie et al (1993) suggest that job prospects, opportunities for employment rehabilitation, the patient’s motivation to work and other psychological factors may be taken into account in assessments of incapacity. Only one reference is made in the literature to the patients’ gender being an influencing factor on GPs’ certification behaviour. Brage and Reiso (1999), based on a survey in Norway, found that primary care physicians were more willing to certify men as medically unfit to work, than they were women.

Corden et al. (2001) describe the issue of medical certificates in the UK by GPs for reasons of grief to parents whose child is terminally ill or has recently died. In some cases, the GPs encouraged the parents to take sickness absence. Problems and distress were experienced by some parents for whom the fact that the certificates had to describe their condition in terms of anxiety or depression became a self-fulfilling prophecy.

GPs’ own characteristics and personal attitudes may also make a significant impact on the outcome of certification (Luz and Green, 1997; Tellnes, 1989; Rutle and Forsen, 1984; Condren at al, 1984). GP age has been found to influence their certification practice (Condren at al, 1984). Rutle and Forsen (1984) identified that in Norway, proportionally more certificates were issued by doctors aged 60-69, than by those aged 30-39. The duration of certificates has also been discovered to be longer from older GPs (Tellnes, 1990).
GPs’ gender has been found to have little relationship to certification practice (see for example, Rutle and Forsen, 1984). However, the study by Brage and Reiso (1999) conducted in Norway suggests not only that primary care physicians generally assessed women’s ability to work as less reduced than men’s, but also that there may be a relationship between the gender of the GP and the gender of the patient. Male GPs were found to be more lenient on male patients than they were on female patients.

Rutle and Forsen (1984) identified that in Norway, higher levels of postgraduate training led to lower levels of sickness certification. An additional observation was that GPs who worked part-time as industrial medical officers, or did part-time work in medical assessment for benefits, gave certificates of a shorter duration (Rutle and Forsen, 1984). Relevant training and clinical experience may therefore have an effect on the likelihood that the doctor will issue a certificate.

A number of writers have described how GPs are at a disadvantage in sickness certification, as they are rarely in possession of the information required about the circumstances and demands of their patient’s occupation or workplace, and are also not well equipped to assess functional or occupational, as opposed to medical, capacity (Luz and Green, 1997; Aylward and Locascio, 1995; Murfin, 1990; Toon, 1992; Mayhew and Nordlund, 1988). This contributes to GPs’ dislike of the certification role.

The extent and nature of GP knowledge of the certification system is described in the literature as a further possible influence on certification practice. There is concern that GPs may not have an adequate understanding of the system and procedures (Hall and Hamilton, 1993; Murfin, 1990). In many cases, GPs learn to issue certificates by trial and error (Luz and Green, 1997; Tellnes, 1990).

Rutle and Forsen (1984), based on research conducted in Norway found that whether GPs were in a single or joint practice made no difference to their sickness certifying behaviour, but that heavier workload and a higher rate of consultations per hour led to higher levels of certification.

Maintaining a good relationship with their patients is a central consideration for GPs (Toon, 1992, Ritchie et al, 1993). It is important for GPs’ therapeutic role that patients trust their GP and that they ‘always feel able to come back’ (Chew-Graham and May, 1999).

Ritchie et al (1993) raise the question of why the doctor-patient relationship becomes so important in GPs’ role of issuing long term sickness statements. They conclude that when the GP questions the continuation of sickness statements, the ‘trust’ between patient and doctor can easily become undermined and confrontation can also ensue.

2.3 The conflicts surrounding sickness certification
Accounts of GPs’ experience of sickness certification include feeling uncomfortable (Aylward and Locascio, 1995), feelings of reluctance and suspicion, of being manipulated (Hall and Hamilton, 1993), of conflicts of loyalty (Fried, 1998) and of being pressurised. Mayhew and Norlund (1998) for example, reported that in the USA 41 per cent of family doctors felt pressurised to write unwarranted excuses.

The ‘sick role’ (Parsons, 1951) is a socially ascribed role which brings with it a set of social expectations of a particular type of ‘sickness’ behaviour (Waddell and Waddell, 2000; Wolinsky and Wolinsky, 1981). The important aspect of the sick role, is not the medical condition, it is the fact that its status and expectations are accorded by society. Sick role theorists are keen to point out that the sick role is not a deviant way of behaving, it is an acceptable adaptation and way of dealing with impairment as a result of illness (Johnson et al., 1988).

In its original Parsonian form, the sick role has four elements:

- the individual is not responsible for his/her condition;
- the individual is exempt from normal task and role obligations;
- recognition that being sick in an undesirable state;
- an obligation to make an effort to recover.

Although normally seen as a response to symptoms, some writers argue that the sick role could also be brought about because of the appeal of the advantages to be gained, such as exemption from normal tasks and obligations (Johnson et al., 1988).

There is a need for the sick role to be legitimised, normally by a doctor. Thus, it is argued that the sick role interacts with the doctor’s role, creating a relationship of dependence and passivity (Mayou, 1984).

There has been significant debate and criticism of the sick role concept. Crossley (1998), for example, argues that more recent ideologies of patient empowerment challenge the dependency relationship which is implicit in the sick role concept.

The sick role has particular relevance for the study of sickness certification, and the role of the GP in medical certification. One of the key aspects of the sick role is that the individual is exempt from normal tasks and obligations, as happens during sickness absence. The medical certificate provides the mechanism which legitimises the sick role.

2.3.1 Managing the sick role

2.4 Patients returning to work

Feuerstein et al. (1999) found that, assuming similar levels of illness, the factor that most affects people’s likelihood of returning to work is their intent to do so, combined with work availability.
People who, according to Stafford (2000) are most at risk of losing their jobs as a result of a long-term episode(s) of sickness absence are those with the following characteristics:

- Male;
- Older;
- Working in construction, transport, communication and manufacturing industries;
- Blue collar workers;
- People suffering from musculoskeletal disorder, stress, depression or anxiety and circulatory disorders.

Although it is likely that the GP may have an influence on the patient’s return to work, a survey conducted in 1993 (Erens and Ghate, 1993), found that only a quarter of recipients of long-term sickness benefit had discussed returning to work with their GP, and in only 40 per cent of cases was the length of the certificate discussed. Ritchie et al (1993) describe some of the areas of greatest uncertainty for the GPs in making judgements about a return to work. These include the patients’ potential for alternative occupation, the patients’ potential for retraining or occupational rehabilitation and opportunities for occupational assessment.

Employers and employment practices are also likely to influence return to work behaviour. Different places of work have different ‘absence cultures’ (Luz and Green, 1981) and different official policies to sickness absence. According to a study conducted in the UK, more than 90 per cent of employers of over 2000 staff have a written policy on sick days. Eighty per cent of those employers interview employees on their return to work (Institute of Personnel and Development, 2000).

The failure of employers to recognise ‘convalescent ability’ (Church, 1998), may inhibit the return to work (Agius et al 1995), extend periods of sickness absence, or affect the patient’s psychological condition. The latter could lead to adoption of the ‘sick role’ (Parsons, 1951) which could give rise to a long-term or permanent absence.

Burchardt (2000) points to the problem of transitions between periods of sickness, arguing that insufficient attention has been paid to supporting people to sustain their employment after a relapse/period of ill health.

2.5 Systemic and procedural issues

There is little in the literature about the systemic and procedural issues of sickness certification. There has been a limited debate about the role and efficacy of the Med 3 and Med 4 certificates, which, it has been suggested, encourage inadequate information from GPs (Church 1998, Ford, 1998). Ritchie et al, (1993), suggest that there is a need for independent assessment of capacity for work and the need for feedback on decisions and judgements.
A significant proportion (in 1997, this figure was 60 per cent, as estimated by the National Association of Citizens’ Advice Bureaux) of patients whose state incapacity benefit claims are disallowed through the Personal Capability Assessment, make an appeal against the decision (National Association of Citizens’ Advice Bureaux, 1997). In many cases, GPs will be involved in providing supporting evidence to the appeal. This is voluntary on the part of the GP and is not an NHS requirement of their role. Most claimants who appeal use some form of external advice (Porter, 1997). This is normally the Citizens’ Advice Bureau, but could also be GPs (whose role is supportive as they are not experts on benefits rules) or other sources. Of the appeals against decisions, 41 per cent are resolved in the applicants’ favour (National Association of Citizens’ Advice Bureaux, 2000).

McCormick (2000) discusses the transitions onto IB, and within that the role of GPs, giving examples of the dilemmas, conflicts and resentment experienced by GPs in their sickness certification role. He points out that unlike many other bodies, GPs are trusted by their patients and recommends that GPs become more involved in the complementary referral of patients.

The added pressure on GPs’ time created by paperwork, including medical certificates and forms, is recognised in a recent government publication (Cabinet Office, 2001). Measures are described which are intended to relieve this burden. They include:

- sick certification will be integrated into the hospital discharge process so that hospital doctors and consultants will not refer patients to a GP solely for the purpose of obtaining a sickness certificate;
- the role of GPs and other health professionals in providing reports and certificates for employers will be clarified;
- subject to successful pilots the power to certify incapacity for work will be extended to nurse practitioners.

The literature on GP prescribing mirrors many of the themes raised in this chapter on GP sickness certification. The importance, for example, of the GP-patient relationship (Stevenson et al., 1999; Bradley, 1992; Britten et al., 2000) and patient expectations (Britten and Ukoumunne, 1997) are cited as key influences on GP prescribing behaviour. Bradley (1992) identifies a number of patient and GP factors which influence the way GPs prescribe. These are not dissimilar to those identified in relation to sickness certification.

2.5.1 Parallels between sickness certification and prescribing

The literature on GP prescribing mirrors many of the themes raised in this chapter on GP sickness certification. The importance, for example, of the GP-patient relationship (Stevenson et al., 1999; Bradley, 1992; Britten et al., 2000) and patient expectations (Britten and Ukoumunne, 1997) are cited as key influences on GP prescribing behaviour. Bradley (1992) identifies a number of patient and GP factors which influence the way GPs prescribe. These are not dissimilar to those identified in relation to sickness certification.

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8 However, unlike prescribing, a sickness certificate can only be issued where there is a specific disease or bodily or mental disablement.
Table 2.6 Patient and GP factors which influence GP prescribing

<table>
<thead>
<tr>
<th>Patient factors</th>
<th>GP factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age</td>
<td>• Concerns about drugs</td>
</tr>
<tr>
<td>• Ethnicity</td>
<td>• GP role perceptions</td>
</tr>
<tr>
<td>• Social class</td>
<td>• GP expectations of self</td>
</tr>
<tr>
<td>• GP knowledge of the patient</td>
<td>• Uncertainty</td>
</tr>
<tr>
<td>• GP feelings about the patient</td>
<td>• Peer influences</td>
</tr>
<tr>
<td>• Communication problems</td>
<td>• Logistic factors</td>
</tr>
<tr>
<td>• GP-patient relationship</td>
<td>• Negative experience</td>
</tr>
</tbody>
</table>


Inadequate information and communication is referred to as a particular problem with GP prescribing. Research by Britten et al., (2000) found that a lot of prescribing practice was characterised by guesses, inaccurate assumptions and misunderstandings. They conclude that these problems are related to a lack of participation of the patient in the consultation.

A number of sources suggest that GPs vary widely in the extent to which they are amenable to reflecting on or monitoring their own prescribing practice, either in terms of quality or cost (Weiss et al., 1996; Ryan et al., 1996; Carthy et al., 2000). A study by Ryan et al (1996) suggests that if GPs do take cost into consideration in their prescribing, they are often inaccurate in their cost estimations.

Avery at al., (2000) and Harvey (1998) discuss the specific characteristics and problems of high-prescribing practices. Avery at al., (2000) proposes that recommended approaches for the control of prescribing costs should take into account the range of different characteristics of high and low prescribing practices.

2.6 Conclusion

The literature review has identified a number of gaps in the information currently available about the role of GPs in sickness certification. The most obvious gap is literature which relates to the UK, as apart from the earlier DSS (Department of Social Security - now the Department of Work and Pensions) study (Ritchie et al., 1993), the most relevant documents are based on research in countries with a different contextual environment. Other significant gaps relate to GP behaviour in sickness certification and the factors which influence their decision-making. The influence of practice characteristics on certification, for example, is an area where internationally there is almost nothing written.
When GPs issue medical statements to their patients, they sign a declaration about the advice given on the individual’s fitness for work. The Med 3, which is the main certificate used for this purpose, advises patients either that they ‘should refrain from work’ for a specified period or that they ‘need not refrain from work’. Either way, the GP has had to make a judgement about the patient’s capacity for their normal employment or type of work. Alternatively GPs can advise the patient that they need not refrain from their work at the same time as advising, in the Med 3 notes section, that certain work restrictions or adjustments would be appropriate.

This chapter describes the process that GPs go through in order to fulfil this role in sickness certification. After providing some contextual information on GPs’ views on their role in certification, the chapter then looks at how the decision is made and the various influences upon it. It then considers the dilemmas that GPs face in assessing incapacity and how these eventually become ‘resolved’. The chapter concludes with a description of the different approaches that GPs have to deciding on fitness for work and the factors that cause these to vary.

3.1 GPs’ views on their role in sickness certification

The remaining chapters of this report explore in detail how GPs view and perform the various activities in which they are involved to provide medical evidence about incapacity for work. However, all of them held what might be termed a wider view about the place of sickness certification within a family practitioner’s workload. This section presents a brief overview of these views as a context for the sections that follow.

Three main perspectives were expressed when GPs were reflecting more generally on their role in sickness certification. First, there were some who would prefer to have no role in certification at all. This was partly because they felt that all the assessments and procedures that are attached to advising patients on their fitness to work are not a core part of what they want to do or were trained to do as general practitioners. They also saw certification as creating difficulties and dilemmas for their relationship with their patients and in managing their overall workload. They had a strong sense that any time spent negotiating on fitness for work and certification could be far better used in other aspects of clinical care which they perceived as being of more direct benefit to their patients’ health.

* A more detailed discussion of the different certificates and reports used to provide medical evidence is given in Chapter 6.
‘I think that there should be some independent person to give certification… it should not be part of the GP’s job to do certificates… it would bring down the amount of work we do… we can be doing some more beneficial work for the patients, those who are really ill…’

(Male, 22 years as GP, single handed, inner city area)

‘The big issue really, is the sort of conflict between being a patient’s representative and also being the person that is stating whether they are fit for work or not… it puts you in conflict with them… they can fall out with you… I think as GPs we like to get on with people well, so you don’t really want to start and get into a situation where there could be conflict between you.’

(Female, 9 years as GP, group practice (7), urban area)

At the other end of the spectrum are some GPs who both value their role in certification and want to retain it. There are a number of reasons for this. First, they see it as part of a GP’s contract to perform the role. Second, they see it as an integral part of the management of patients’ illnesses. Third, they feel the certification role helps in allowing them to respond to patients’ requirements for more holistic care. Last, and possibly most important, the GPs feel strongly that only a patient’s GP has the required information, and in particular the required depth and breadth of information, about the patient and their surrounding circumstances to make a sound judgement of their capacity for work.

‘I think it is actually quite an important part of our role… it’s sort of giving them permission to be ill… and saying you do need time off work… so I enjoy that aspect, my role of certification’

(Male, 20 years as GP, group practice (3), rural area)

‘The fact that you know the individual, their past history, their social condition, their work-place… we’re in the best position to assess fitness to work.’

(Male, 24 years as GP, group practice (6), rural area)

A third group of GPs think that this role sits rightfully within the duty of a GP, but feel that some modifications to that role would be beneficial. For example, they think the Benefits Agency should ‘take over’ earlier than six months at perhaps three months or less. Alternatively they think GPs should only be responsible for certificating the more simple and straightforward cases, or to have a role in helping patients to work but not act as the final arbitrator.

‘For short term it’s fair enough, one or two weeks… when it goes on for four weeks or longer I think it should be assessed by somebody else.’

(Male, 5 years as GP, group practice (4), urban area)
It should also be noted that, irrespective of such perspectives, the longer serving GPs, who clearly remembered their roles prior to 1995 when IVB was also dependent on a GP’s certificate, thought the ‘new system’ was very much better in terms of the demands it placed on family doctors.

3.2 The process of judging incapacity

DWP Guidance advises GPs that:

‘Advice regarding fitness to work is an everyday part of the management of clinical problems and doctors should always consider carefully whether advice to refrain from work represents the most appropriate clinical management.’

(IB204, DSS, 2000, p4)

GPs are therefore required to base their certification judgements on clinical management and to take into account only the patient’s medical condition and the resultant functional limitations. This process which is formally required by GPs is shown in Figure 3.1.
Figure 3.1 Official requirements on GPs in relation to judging incapacity – advice to patients regarding fitness to work

A process comprising:

### Assessment of:
- The nature of medical condition - including length condition is likely to last
- Any functional limitations (physical/psychological)
- The occupational requirements

### Clinical management including:
- Use of clinical guidelines
- Reasonable adjustments to enable work to continue
- Risk to patient/workplace (physical/psychological)
- Is further time/investigation needed?

**Iteration gives appropriate weight to each factor**

**ADVICE TO REFRAIN FROM WORK**

- NO
  - Assess as capable of usual work
    - Refuse further certification
  **YES**
    - Assess as incapable of usual work
      - Provide certificate until next consultation or specified date
The DWP Guidance presents a list of factors, which GPs may wish to consider when providing advice to a patient about fitness for work:

- The nature of the patient’s medical condition and how long the condition is expected to last.
- The functional limitations which result from the patient’s condition, particularly in relation to the type of tasks they actually perform to work.
- Any reasonable adjustments which might enable the patient to continue working.
- Any appropriate clinical guidelines.
- Clinical management of the condition which is in the patient’s best interest regarding work fitness (IB204, DSS, 2000, p16).

In practice, however, interviews with GPs revealed that the process used by GPs to judge whether a patient is fit for work is a complex one which often differs from the official guidance. It is represented diagrammatically in Figure 3.2 which shows it as a linear process involving a number of stages.
Figure 3.2 Description given by GPs interviewed of the process they used in practice to judge incapacity

A process comprising:

**Assessment of:**
- The nature of medical condition
  - including length condition is likely to last
- Any functional limitations (physical/psychological)
- The occupational requirements

**Clinical management including:**
- Use of clinical guidelines
- Reasonable adjustments to enable work to continue
- Risk to patient/workplace (physical/psychological)
- Is further time/investigation needed?

**DEMOGRAPHIC AND PATIENT-RELATED FACTORS, SUCH AS:**
- AVAILABILITY OF WORK
- AGE
- SOCIAL, FAMILY AND FINANCIAL CIRCUMSTANCES

**INFLUENCE SOME GPS’ JUDGEMENT ABOUT THE PROVISION AND LENGTH OF CERTIFICATION**

**ADVICE TO REFRAIN FROM WORK**

**NO**
- Assess as capable of usual work
- Refuse further certification

**YES**
- Assess as incapable of usual work
- Provide certificate until next consultation or specified date
In reality, the judgement may be made instantaneously or require deliberation; it may involve a number of different factors or be very evident solely from the patient’s condition; and it may be iterative in form. Hence the pathway through the process may be smooth, simple and straightforward; or may involve uncertainty, reconsideration, or a number of ‘loops’, and be experienced as difficult and stressful. The following passages, whilst rather lengthy, are quoted here in order to display the differing tiers of complexity.

‘I think if somebody comes in with that [back pain] I have to look at the back pain and I should not presume that they’re at it, right? In terms of giving lines [certificates]... I probably eh – probably would give them a line initially. Eh, but I would also investigate it, you know, examine them. You know, try and exclude sinister causes, I mean usually these guys are the older guys and sometimes you get sinister causes for back pain so you’ve got to look … and then I’ve got to decide, eh, you know, if they’re not getting better then I don’t find any cause and they’ve considered physiotherapy, I think that has to be reviewed that they get – I don’t think they should be on the treadmill, getting lines all the time. Then I’ve got to decide – shall I fall out with them if I think they’re at it or do I do a thing for them to get done [assessed by the BA Medical Services Doctors] on the sly. And I sometimes do… fill in the whatever it is fill in the Med 7 [RM7].’
(Male, 7 years as GP, single-handed practice, inner city area)

‘It’s [certification is] part of a package of treatment that we’re giving to the patients I suppose, it might mean pills and time off work or it might just be time of work or – it’s possibly the therapy I suppose we see rather than they’re not capable of working – rubber-stamp, have time off, it’s all more subjective than that…Yes, and it’s not just the illness, it’s their total health, the whole sort caboodle, family, work, social interactions, everything else that goes up to making somebody’s general health, not just a particular illness. It’s very difficult to confine advise time off into just being because of their physical complaint when there’s everything else to take into account how this physical complaint affects their home life, affects their interaction with friends, you know, and leads to this ultimate health.’
(Male, 4 years as GP, group practice (5), rural area)

3.2.1 Assessing condition

The first stage of the process in judging capacity, which all GPs go through, is to assess the patient’s condition. For patients with short-term acute illness, this is likely to be the only stage and a certificate will be issued on the basis of the condition alone. Similarly, for longer term acute illnesses of a serious nature, such as heart disease, cancer, operations (e.g. hernia, hysterectomy), injuries and recurrent phases of some longer term chronic illnesses (e.g. arthritis, MS), assessments of incapacity tend to be reasonably clear cut and a certificate will be issued. The length of time a certificate will be issued for depends on the GP and on the nature of the condition. This is discussed further in Chapter 4.
A second important element of the judgement about incapacity is to take account of the requirements of the patient’s usual occupation. This requires some assessment of whether the patient, with the condition they have, can be expected to adequately do their usual work. In order to make this assessment, GPs generally have to rely on what the patients tell them about the demands of their work or what the doctors themselves know about the type of work involved.

Where patients are unemployed, GPs have to decide if the patient could do their usual type of work or the work they were trained for. While in theory this should be the only consideration in periods of sickness under six months, in practice, many GPs are influenced by their perception of the patient’s potential to get a job, or the likelihood of them finding employment.

Although the guidance to GPs requires the GP to take into account medical condition only, in practice there are many circumstances in which GPs take the patient’s age into account in their judgements about capacity for work. This is particularly so at the youngest and oldest ends of the age spectrum. In the case of young patients, GPs described being particularly vigilant to ensure that the habit of unnecessarily long sickness absences did not set in at an early age.

Patients who are nearing retirement age are generally treated more leniently by GPs than other age groups. This was found across the spectrum of GPs, irrespective of GP or practice characteristics or general approach to sickness certification. This was also particularly so when a patient had lost their job after a history of stable employment, had a condition that made hard manual work more difficult or generally had difficulty keeping up with changes in the workplace. While some GPs perceive this special treatment as a forgivable bending of the rules on their part, others are more unabashed.

There may be situations where assessment of the patient’s condition, age and/or occupational requirements have not led to a judgement about incapacity. In those cases, although DWP guidance states that GPs should take into account only medical condition and resultant functional limitations, in practice, GPs may take a number of other patient related factors into account. These are numerous but broadly fall into the following groups:

**Motivation** to return to their job, to work or to find work.

**Psychological frailty** and whether the patient displays a level of stress, anxiety or depression that may make it difficult to return to work or looking for work.
Occupational ‘readiness’ and whether the GP thinks the patient has the capability or adequacy to find work or hold down a job.

Financial circumstances and whether or not the GP believes that the patient will lose financially by being unable to claim an incapacity benefit or by returning to work.

Family circumstances/living arrangements and whether there are demands or stresses at home that may make it difficult for the patient to focus on work.

Caring responsibilities that require the patient’s time or attention and may be difficult to accommodate alongside work.

If any of these factors create doubt in the GP’s mind about the ‘capability’ of the patient to work, then the doctor is likely to issue a certificate. As might be evident from the nature of some of these factors, they are more likely to come into play in areas of high unemployment or where the patient population is characterised by other disadvantages.

If GPs are undecided, or perhaps unconvinced, about their patient’s level of incapacity they may simply decide to defer for a while and wait to see if time brings any change or improvement. Alternatively, they may feel that a second opinion on the individual’s condition is needed to help explain why recovery is not happening at the expected rate. They will therefore refer to physiotherapists for assessment and treatment or to medical specialists for further clinical examination, investigations or treatment. The reasoning behind the call for further investigations may be twofold. First, to genuinely rule out medical conditions which are difficult to detect. Second, to provide an ‘external’ confirmation for the patient that their condition does not merit sickness absence. GPs described how the use of an external source could soften the impact on the GP-patient relationship of an unpopular judgement.

‘If there’s improvement, all well and good, you know, you deal with it and get them back to work. If there is no improvement then it might be a question of doing a re-examination, reassessing what your findings are, possibly ordering some investigations ... if I was still fairly certain that this person wasn’t genuine ... at the second interview you might take it a little bit further down the line, try and maybe explore some of the work difficulties that they’re having but then you may still issue a certificate because you’re waiting for investigations as evidence for you so that at a later stage you might say, well, these are normal, you know, your examination findings don’t tie up, you know, I believe that there is something happening that’s causing the disincentive for you to go to work, you know, can we talk about that a bit, you know, what sort of things are going on? I think that’s probably what would happen at that stage but, you know, you might need three appointments to get to that stage.’

(Female, 10 years as GP, group practice (6), rural area)
This is also the stage that a GP might use an RM7 or some other flagging mechanism to call for some assessment or investigation from the BA (see Chapter 5). Again, from the GPs’ perspective it is a way of ‘buying time’ but with some acknowledgement of their own doubts about the patient’s capacity for employment.

3.2.6 Assessing risk

The risk of damage to an individual’s physical or psychological health, through a return to work, is of consequence throughout the judging process. However, there comes a point where GPs almost begin to defend their decision to continue issuing statements on the basis of the possible hazards that working might have for their patients. It is also in this context that worries about perceived litigation threats can enter a GP’s thinking.

‘It’s difficult, isn’t it, because you’re on a sticky wicket if you say to someone your symptoms aren’t genuine, period, without maybe taking it a little bit further down the line.’

(Female, 10 years as GP, group practice (6), rural area)

‘…you have to err on the side of caution because if they have got a pain and you send them to work and it gets worse, you’ve had it basically…you haven’t got a leg to stand on…legally’

(Male, 4 years as GP, group practice (3), inner city area)

GPs described their perceptions of the threat of litigations, which may have been greater than the reality.

‘If somebody harms himself while he is working and you made him fit to work then he is going to sue the doctor, the doctor made me fit to work and I was not fit to work’

(Male, 22 years as GP, single handed, inner city area)

The process described above, which GPs use to judge capacity for work, takes place mainly in a busy surgery and is neither as logical or as explicit as the above description suggests. Nor, as noted earlier, does it have this exact chronology in every case. But most GPs refer to these elements or ‘stages’ when describing how they judge incapacity for employment. In the following two sections we consider in more detail the influences that affect the process and the difficulties GPs have in making their judgements.

3.3 Factors influencing the incapacity assessment process

There are a number of factors that influence how the process of judging incapacity takes place. With some exceptions, most of these factors serve to prolong rather than speed up the process. They are as follows:

3.3.1 Referral for specialist medical assessment or treatment

There are many circumstances in which GPs will need to refer their patients either for further clinical assessment or some form of treatment. This would happen, for example, if a patient had a complaint which was preventing them from working, but the doctor could find nothing wrong, they might refer them to the hospital specialist who may then arrange further investigations and treatment. A return to work for the patient
would often only be possible after all possible explorations and referrals have been made. Almost without exception, GPs noted that these referrals were likely to involve quite lengthy periods while patients waited for appointments. During such times, GPs usually continue to issue medical statements unless the patient has made a marked recovery and asked to return to work.

3.3.2 Knowledge of the patient

In cases where GPs had, over many years, acquired an extensive knowledge of patients, the level of understanding attained is useful in making a judgement about capacity to work. GPs found it easier to make decisions about a patient’s capacity for work if they knew them well. It allowed them to take into account previous medical and employment history as well as personal factors such as attitudes to work. It also helped GPs to judge the best way to approach discussions of the return to work with their patients (see Section 4.1). Conversely, patients that are new to the GP or whom they do not know well make assessment more difficult and there was more of a chance of giving them ‘the benefit of the doubt’.

3.3.3 Busy surgeries

The time available in the consultation was felt by some GPs to have a significant effect on their certification practice. The average consultation time for each patient was thought to be insufficient to deal adequately with clinical issues, treatment and prescription as well as issues relating to sickness certification. Moreover, it was common to find that the consultation time was running out before any discussion about the need for a certificate had begun. In such circumstances, and particularly when the surgery was busy or when surgery times were coming to an end, it was easier ‘just to sign’ rather than begin any new assessment of incapacity if this was not already clear.

‘We have seven and a half minute consultations … to get through the day’s workload that’s the sort of speed that you have to work. So you have to allow them two or three minutes to tell [you] what’s wrong, otherwise they go home aggrieved that you haven’t listened to them. Then perhaps a couple of minutes to get them undressed and examined – the relevant bit that needs to be examined. Then you have to make a sort of mental diagnosis, print off a prescription if they need one. So you’re looking at a very tight schedule. And at the end of that is usually the agenda of, “I can’t work, I need a sick note”, and so on. So you’ve literally got about ten seconds to make a quick decision – do I give you the sick note or not, and that’s - the way the consultation is centred isn’t a high priority and you’re running late and you say, “Here it is, two weeks, you go”’.

(Male, 10 years as GP, group practice (3), urban area)

It was also observed that in a busy surgery, GPs are grateful if someone wants a sick note, because it is quick and easy.
'If you’re running late, if you’ve had loads of extras, you see someone who is on long-term sick who has only come in for, you know, they just want their sick note and you’re half an hour late, there’s a disincentive to discussing getting back to work because you just write out your sick note, you give them it, and then you’re back on time, marvellous.'

(Female, 10 years as GP, group practice (6), rural area)

Some GPs also described how, by the end of a surgery they are likely to be more tired and therefore less inclined to begin any prolonged discussion of fitness for work. Similarly patients who come for appointments during emergency slots or without an appointment are seen as problematic in these respects as there is very little time at all to investigate.

3.3.4 Avoidance of confrontation

GPs are acutely aware that some of their patients are likely to be unhappy if they judge the individual to be fit for work and hence refuse or stop certification. In such circumstances, failure to award a certificate will often lead to a prolonged discussion or argument at best and the threat of physical violence at worst. It may also lead to the patient moving to another partner or even changing practices. In the main, GPs want to avoid such confrontation because it compromises other roles they want to fulfil for their patients. In cases of any doubt therefore, or when they have had a particularly stressful or tiring day, they are more likely to continue, rather than discontinue, certification.

‘I think we are too chicken really to confront these people ourselves…because you don’t want the patient to come in and bash you over the head or saying why did you get my sickness benefit stopped. The reason is you don’t want to be seen as being nasty to patients…I mean sure you could go around disagreeing with patients all the time and that’s no problem if you’re happy to do that, but then I think it makes it difficult if you’re then looking after them in the long term.’

(Female, 9 years as GP, group practice (6), urban area)

3.3.5 Deferring responsibility

There are a few GPs who respond to their certification role very warmly but some react very adversely to the intrusive effect they feel it has on their clinical role for patients.

‘It would save a lot of time and a lot of paper work [if the certification role was removed from GPs] and from a doctor-patient relationship point of view it would definitely, in certain cases, be a lot easier.’

(Female, 4 years as GP, group practice (5), urban area)

There are also GPs who feel, for reasons ranging from lack of skills to lack of prioritisation, that they are not able to, or not comfortable with, taking the responsibility for this task and look for opportunities to transfer responsibility. This may involve sending in an RM7 form to speed an assessment from the BA, making a request to a consultant or perhaps a physiotherapist to say whether the patient is fit for work, or simply biding time until six months has elapsed and the PCA system ‘takes over’. 
‘It’s often very difficult to confront somebody, en, in the surgery setting, and therefore having the RM7 form just highlights it to the people in the Benefits Agency, that you think maybe, you know, they’re not as genuine as they’re making out.’

(Female, 4 years as GP, group practice (4), urban area)

‘…sometimes I’ve got to decide – shall I fall out with them if I think they are at it or do I do an RM7… sometimes I do fill in the RM7 and get them seen that way.’

(Male, 7 years as GP, sole practitioner, urban area)

Many of the above factors are underpinned by GPs’ more general views about their role as a provider of medical statements and the ‘policing’ function that this can bring, as previously described.

3.3.6 Patient expectations

Patients were not interviewed as part of this study. However, GPs did report their perception that many patients come to the consultation with a GP with expectations of receiving a sickness certificate which GPs believed were sometimes the sole purpose for the appointment. GPs believed that the patients’ expectation may have been influenced or fuelled by their experience with other GPs, the experience of friends, relatives or colleagues, or by the Jobcentre who sometimes advise people to go to their GP to obtain a sickness certificate.

3.4 Approaches to judging incapacity

Although the above process describes what GPs do when assessing incapacity for work, it is clear that there are some differences in the way in which they approach – or at least try to approach – their certification role. Their approaches can be seen to lie on a continuum which at one end tries to focus on the patient’s condition and occupation and little else and at the other commonly takes account of multiple factors.

Although described below as three discrete ‘approaches’, in reality the distinctions are blurred, and GPs may move up and down the continuum. There was a widespread view that it was very easy to move up and down this continuum. Some thought they had moved position over the course of their career, others felt they varied both with individual patients and depending on their general ‘disposition’ at the time of decision making.

3.4.1 Condition and occupation dominant

Some GPs try very hard to restrict their assessment of incapacity to the patient’s condition and the impact this would have if they were engaged in their usual occupation. This corresponds to the approach laid out in the guidance for medical practitioners (IB204, DSS, 2000, p16). These GPs may be ‘rule followers’ or may be motivated by strong personal beliefs, work ethics or their own personal experience of sickness absence. In the following three examples, names of the GPs and other identifying details have been changed in order to protect anonymity.
Example 1

Doctor Ahmed has been practising as a GP for around 15 years. He has a special interest in occupational health and is the senior partner in a busy medium sized practice in an urban area. There are high levels of deprivation and unemployment among his practice population, and a high incidence of mental illness and social problems. Dr Ahmed’s approach to the process of judging capacity to work, which is illustrated below, makes him unpopular with some patients. On two occasions he has had things thrown through his window, which he associates with his tough line on certification.

‘If it’s, sort of, a genuine patient, first time offender if you like, you tend to, give them the certificate. But when they start hitting the sort of four-week mark, you then really start looking, well what is going on? Why can’t they go back to work? …But where you can’t find an explanation, then you start challenging why…it might be the fourth week or it might end up with the sixth or seventh week but sooner or later I will challenge them. I’d like to do it earlier but some people just get left because I’m busy that day …right at the end when they raise the medical certificate, I’ll say, “well actually, I think you’re a lot better. You know, I’ve examined you, you’ve changed, you can move now…”’

‘…If you’re looking at sort of social factors and, psychological factors – no. Because at the end of the day I’m a firm believer that if you were in a society where there weren’t benefits then those factors wouldn’t play a part. You’d just go out and work. You know, so I think the more needy you are the more inclined you should be to go and work so, in fact, the more desperate your life is, the better it is for you to go out and take your mind off your life and earn a bit more than you’re getting on the dole, or on sickness benefit and improve that life. And it’s only because there’s an easy option that people take it…’

3.4.2 Condition and occupation led, with other influences

In this approach, the GP’s assessment is heavily derived from the patient’s condition and occupation, as above. However, in this case, a very limited number of other factors may be taken into account. Most commonly this is the age of the patient, but may also include real or anticipated (by the GP) difficulties for the patient in obtaining, or remaining in employment.
Example 2

Dr Matthews has been a GP for around 20 years. He has an interest in occupational health and works in a small group practice in a large city. The practice catchment area has medium to high levels of social deprivation and unemployment.

‘I think it wrong that people should be certificated if they are capable of some work…these people who, if you like, feign illness or who are demanding the certificates when they are not justified on medical grounds I feel are abusing our system and are wasting money…

…If it’s a heavy sort of job you know, someone who’s perhaps working on the roads and is swinging a pick-axe or something, if he’s 60 years old and he’s broken his ankle he’s going to be off quite a bit longer than your young fit footballer who’s maybe got a desk job…’

3.4.3 Affected by multiple factors

Although official guidance states that GPs should take into account the patient’s condition and functional limitations only, some GPs adopt an approach to certification which they acknowledge takes account of multiple factors and influences when making their judgements about a patient’s capacity to work. The medical condition and the patient’s occupation will be important, but a range of other factors are taken into account including the patient’s domestic circumstances, their motivation to work or financial situation. GPs who adopt this approach may be influenced by their broader views on society, social problems and social responsibility. They may have a strong vision of a GP as the ‘patient’s friend’, or may be motivated by empowerment and ownership approaches to general practice.

Example 3

Dr Phelps has been practising as a GP for around 10 years. He is a senior partner in a medium to large practice in a large city, and is actively involved in the local medical community. The practice catchment area has fairly high levels of unemployment and social problems.

‘We see a lot of non-illness so we have to take other factors into account, you know, it’s very much the sort of physical, psychological and socio-economic situations that have to be considered when looking at people’s illness, the physical stuff is fairly obvious. We also have a situation where a lot of people need to work and lose money if they’re not certificated and in work and with the levels of hardship that are available locally, that sometimes plays a part in certification…If somebody has been bereaved and they need to not work for a little while, they would tend to be financially punished unless they’re on a certificate with some sort of bona fide medical condition on it and obviously we would tend to be sympathetic towards their point of view.’
3.5 Difficulties in assessing capacity for employment

It will perhaps be evident from the discussion above that, in certain circumstances, GPs find the judgement about a patient’s capacity for employment a difficult one to make. Indeed, in describing the process, they identify specific difficulties that can arise at different ‘stages’ of decision making and more generally.

3.5.1 Assessing the medical condition

‘Subjective’ or difficult to measure conditions present significant problems for GPs. Musculo-skeletal problems, such as low back pain and low-grade anxiety/stress conditions were mentioned repeatedly in this context. Other conditions, such as chronic fatigue syndrome were also referred to.

Pain Judgements on the level of pain experienced by individuals were often hard to make and some GPs felt that they did not have the skills to distinguish genuine from faked pain. The GPs also talked about the risks for the patient and for themselves that were attached to ignoring patients’ complaints about pain should any damage occur if they returned to work.

Drug-users and alcoholics For some GPs, mostly practising in areas with high levels of deprivation, dilemmas were experienced in making decisions for patients who had problems of alcohol or drug dependency. GPs tended to feel that they could work, or job seek, and that their own and others’ attitudes prevented this.

Cultural and linguistic differences GPs who had a number of patients from black and ethnic minority groups spoke of certain differences in the way specific communities may describe their health problems, which presented, for some GPs, difficulties in interpreting their meaning and making the consequent judgements.

‘…I mean I think there are cultural elements to presentation, say for Asian people for example, will often come and say, “oh, my whole body is in pain and my heart is heavy” and this type of thing, you have to sort of try and interpret that really into what, into the way that people present in the West, and I think sometimes getting to the nub of a problem can be a little bit more difficult…’

(Male, 9 years as GP, group practice (5), inner city area)

3.5.2 Assessing occupational requirements

Generally speaking GPs' training does not equip them with any specialist knowledge of the requirements of different occupations and how these might interact with clinical conditions. They are therefore reliant on their lay knowledge or what the patient tells them, unless there is some contact with the employer (GP communication with employers is discussed in Section 5.5).
‘It makes it very difficult when you’re basically saying whether someone is fit or unfit to work on this production line, but you don’t actually know what the person does on the production line...the most difficult dilemma I find is not knowing what it is that they’re going back to – there’s the nature of the work and the nature of the environment...those are the more difficult issues than the physical problem.’

(Male, 10 years as GP, group practice (2), rural area)

Some GPs may also take into account the extent of stress created by the patient’s work. Working environments or relationships which create or exacerbate the illness can be seen as justification of incapacity for work. But again they are wholly dependent on information the patient gives, which mainly cannot be verified.

GPs also found themselves taking into account the type of work that individual patients might be capable of doing:

‘...it’s always at the back of one’s mind that if jobs were available, you know, the person could work. It may be that they’re not available for their usual work, the one that they’re trained for, etc., so there is a bit of a dilemma there...basically I give the patient the benefit of the doubt, I say, well, look, you know your capabilities, you know your job, you know, you’ve got the best idea, you’re probably in the best position to judge whether you can do it or not. Admittedly that will tend to make certification a bit more frequent but – so over the issue of whether to issue a note I’m fairly, if you like, liberal.’

(Male, 22 years as GP, group practice (4), rural area)

For most GPs, the relationship which they have with their patients is of utmost importance. The activities of assessing fitness for work leading to advice that the patient need not refrain from work poses a threat to this relationship. There was seen to be an inherent tension between their role as a patient’s advocate and being a gatekeeper to financial benefits which the patient may claim. Many GPs, for example, described how they find it extremely difficult, if not impossible, to find a way to express to their patients any sense of distrust or disagreement which they may feel about the individual’s capacity to work.

‘Ultimately our business depends on getting on with people so I’m not prepared to jeopardise patient relationships for the sake of a sick note, it just isn’t worth my time and it isn’t worth the amount of anguish it is likely to generate.’

(Male, 12 years as GP, group practice (5), inner city area)

If the relationship between GP and patient is good, GPs find it easier to certify and easier to be firm with the patients. Where GPs had a thorough knowledge of the patient, they find it easier to be sure whether or not they should issue a sickness certificate. There was less need for ‘benefit of doubt’ certification. For some GPs, a strong GP-patient relationship means
that they can be firmer as they expect the patient to accept it due to the mutual understanding and trust between them. However, others are loath to put a strong relationship at risk by unpopular certification practice. Related to this, if they like the patient some GPs may feel that they want to help or be more lenient in their certification. However, conversely, if they do not like the patient, they may overcompensate by certificating where they may not otherwise have done so.
When issuing certificates for sickness absence GPs need to consider whether, how and when their patients might return to work. Although decisions about the patient’s incapacity and his/her potential to return to work become very entwined, they raise different issues in terms of GP interventions and clinical decisions. This chapter explores GPs’ approaches to managing the return to work and the factors that influence their thinking.

4.1 Approaches to managing the return to work

By way of context, it is important to note three general factors that have a bearing on how GPs handle the management of a return to work. The first is their perspective on the value of work in maintaining and promoting health. Some GPs are very clearly of the view that work makes a significant contribution to keeping people well because of the sense of purpose, social engagement and esteem it carries. They therefore place getting people back to work as a reasonably high priority in the management of their patients. A second group, whilst not disagreeing with this perspective in some occupational spheres, also identify many of the stresses and strains that work can bring.

While both groups are supportive of the need to have time off work in the case of clearly identified illness or even for short ‘restorative’ periods, those with a stronger view about the value of employment are likely to keep work more clearly on the agenda. Others give more priority to allowing their patients to fully sort out their problems before carrying on, or even providing ‘a way out’ for those with difficult situations at work.

A second, and related, factor concerns the distinction that GPs make between patients who are on sickness absence from work and those who are on sickness absence from jobseeking. Some GPs are more aware than others that by stopping sickness certification they are returning their patients to unemployment – and probably to a lower benefit income. In areas of high unemployment and/or where the labour market is in some way depressed, they find this hard to accommodate ‘in the patient’s best interests’.

Finally, the GPs’ perspective on their role in sickness absence ‘management’ can affect how far they will intervene in aiding a return to work. Some GPs, and particularly those who want to disconnect from their role in the award of benefits, see their patients’ employment as outside their sphere of interest as a GP. There is no stated understanding that a return to work might have any bearing on their patient’s clinical condition.
‘[getting patients back to work] I don’t necessarily see that as a major role…because very much the bulk of the consultation is the clinical discussion and how things are going and so on and usually the question of work tends to be a sort of thing at the end…’

(Male, 22 years as GP, group practice (4), rural area)

4.1.1 Some different approaches

Although GPs cannot be easily typecast, it is possible to identify three rather different approaches to managing the return to work. They lie broadly on a continuum as follows:

Firm negotiator

The ‘firm negotiator’ tends to be actively involved in the management of the patient’s return to work/job seeking. Depending on the patient’s condition, they are likely to raise the question of a return to work at an early consultation and to return to it at regular intervals. Goals or milestones may be set, with reasonably regular reviews of progress.

Discussions will involve the consideration of any barriers to returning to work, and where possible ways of overcoming them. If there are any doubts about the patient’s condition or the treatment, referral to a specialist or for assessment will be made. Discussions may also cover the need to consider alternatives to the usual occupation, or suggestions to seek advice. The GPs may also become practically involved, for example by contacting employers.

Firm negotiators are prepared to challenge the patient where needed and may be direct, and at times quite tough in their approach. They are likely to expect the patients to help themselves, and are prepared to refuse certification, or give ultimatums that they will do so, if necessary.

In the following three examples, names of the GPs and other identifying details have been changed in order to protect anonymity.
Example 1

Dr Ayres has been practising as a GP for around 20 years. She works full time and is the senior partner in a small practice, which she shares with a relative. The practice is located in a part of large city, which has comparatively low levels of unemployment and social deprivation.

‘I deliberately say ‘well, what about work? Because this has gone on a long time. What are you going to do?’ We have our ‘make your mind up time’ interview, and usually that’s allocated at the end, you know, I’ll allocate maybe 20 minutes, 30 minutes…but some decision has to be made, and they can’t keep on that indefinitely so we have to decide, look, it’s make your mind up time, which is difficult, but most people actually later will thank you, because you’re actually forcing them to make a decision…I like to see them on a regular basis…I would look at, look at say, ‘you’ve had your time of’…What I usually say is – you know, go home and make a list…Go home and make a list for what you enjoy, what you don’t like. Come back and we’ll analyse it…It works well with maybe patients who are hovering on that way anyway and they just need a little push…There are others who get very angry with you…I just have to tell them that I think that’s how I see it…You’re going to have to make them confront inadequacies in themselves…I’ve got different kinds of handouts and things…It’s hard…but if you want to be the kind of GP that I like being you’ve got to think about your patient and not bully them, but just make them take a step back and look at what’s happening to them…I’m probably kind of more proactive’

Soft negotiator

The ‘soft negotiator’ takes a more flexible, accommodating approach, which they themselves often describe as ‘softly, softly’. Although they are keen to encourage the patient to return to work where possible, they are eager to do this in a gentle, coaxing manner that will not adversely affect the GP-patient relationship. Soft negotiators are unlikely to use confrontational or forceful approaches and tend not to refuse a certificate if the patient insists that they cannot return to work.

A soft negotiator will normally raise the issue of the return to work only after a period of time has elapsed, either awaiting tests or recovery. The approach which they decide to take will depend on the patient’s condition but also on a range of features of the patient’s circumstances. They are likely to see their role as one of giving support and encouragement.

‘…usually into the months…that someone becomes worried about their potential to go back to work…that can start to cause a kind of anxiety on their part which diminishes their health and reduces their recovery rate…I feel that’s where the GP specially has a role to be kind of supportive and say look you are doing well physically let’s not allow the psychological overlay to become a problem’

(Male, 14 years as GP, group practice (3), inner city area)
The discussion of the return to work may involve carefully phrased suggestions such as the possibility of retraining or seeking other advice. The soft negotiator may set goals jointly with their patients, in order to avoid a drift into the sick role.

Example 2

Dr Wiseman has been a GP for four years. She works part-time in a small to medium sized practice. The catchment area has moderate levels of unemployment and social deprivation and is a largely rural area, outside a large city.

‘I mean, there’s some people, you’ve given them a line and I’ve given them a talk about ‘Have you tried to find another job?’ or ‘Why don’t you get some CVs made up?’ And then I deliberately ask them the next month. If I feel I should, I say ‘You really should be looking at something else’. And I find it difficult, because obviously you’re treating the patient and all their family…You don’t want to be perceived as uncaring and untrustworthy… and if they see you as the big bad doc, you worry it interferes with your doctor-patient relationship in other areas…Instead of having a fight with them and signing them off, which for a start gets you all stressed up in the middle of your surgery, it takes ages, you’ve only got seven minutes a patient…there’s been a breakdown in the relationship, maybe if they’re coming in with something else they don’t like you after that. So I quite like it when the Benefits Agency took this thing, it was out of your hands and they went up there and they got found fit for work, and they would come back…and I would say ‘Oh dear, it’s out of my hands now’. My approach just tends to be persistence. Every time they come in, just mentioning it…Just so it’s not as easy for them just to come in… I’ll write on the thing ‘Discussed looking for employment,’ and I’ll say to them, ‘Did you phone up about that job, then? I just don’t say ‘Well, I’m not signing you off again, cos there’s nothing wrong with you.’ It’s not my style, I don’t do that.’

Non-interventionist

GPs who adopt a ‘non-interventionist’ approach are strongly influenced by their patients’ expectations and pace. They may give advice or discuss workplace problems, but should there be cases of difference of opinion, they will give the patient the benefit of the doubt. They are unlikely to give any specific directions or suggestions about the timing of a return to work and will largely leave this to the patient.

In the main, ‘non-interventionist’ GPs do not see the management of the return to work as a key responsibility or a priority in their work. This may be because of their more general adverse attitude to playing a part in sickness certification, because they feel ill-equipped to give advice or direction in this sphere, or because they have an inherent belief that their patients will largely make the right judgements about going back to work.
Whatever the basis of their view, these GPs are unlikely to intervene in their patients’ return to work and will wait for the Benefits Agency and a Personal Capability Assessment to take over.

Example 3

Dr Harwood practices in a medium sized practice in a deprived area of a city, with fairly high levels of unemployment among the catchment population. Dr Harwood has been a GP for approximately three years and works part-time.

‘For me it depends on what the patient is saying…I’m not confident that my subjective assessment is significantly more accurate than their subjective assessments…If they feel like they’re not fit to go back to work, then I tend to go along with that…But if, you know, if the patient is in a job which they’re just wanting to get out of, and they, they’re not going to get another job, then I would be prepared to sign them off longer-term, toward, up until retirement…I don’t feel like I have much impact on it [getting healthy patients back into work]. I leave it to the patient to decide whether they’re ready to go back to work…I’m big into patient empowerment. But there’s a conflict where I have got a gatekeeping role, where I’ve got to protect the DSS budget – well, that’s not really my job, but…I would like to see people not abusing the system, and to a point I am involved in that, I am, yeah, I’m involved in that abuse, because I sign people off where probably there is some kind of employment they could undertake. But for a small, for a significant number of them, um, they get more money when they’re on long-term benefits, and more money means better health, so it’s a balance’.

Inevitably, these three approaches are caricatures and many GPs will combine a mix of different approaches, possibly with patients. Nevertheless, as the case illustrations above suggest, they help to show that GPs do not approach the clinical management of a return to work in a uniform way. It was also evident from discussions that took place in the groups that GPs might change their approach over time, although again not necessarily in the same direction. Some said they had got tougher as they gained more experience and learned how to handle more resistant patients; others said they had become less directive as they realised the difficulties surrounding the effective management of a return to work within existing rehabilitative and employment based resources.

Irrespective of the approach taken by GPs, there are certain common features or stages that occur in the process of guiding the patient’s recovery and return to employment.

4.2 The process of managing a return to work

Irrespective of the approach taken by GPs, there are certain common features or stages that occur in the process of guiding the patient’s recovery and return to employment.

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10 At the beginning of the group discussions, the GPs were shown the three approaches in a short presentation and asked how these fitted with their experience.
4.2.1 Timing

Although the timing of any discussion about a return to work varied with the patient, their condition and the GP’s approach, there was widespread recognition that timing was crucial on two main counts. First, it was important that the patient did not return to work too soon—either before they were fully recovered from their illness or condition or when there was still some physical frailty. Almost every GP gave accounts of patients who tried to go to work too soon, particularly among self-employed people.

‘…we’ve got a lot of patients here who prefer to carry on working…self-employed people, farmers so on and so forth. They don’t want sick notes because, you know they want to be able to carry on working, they’re a hardy, stoical lot’

(Male, 26 years as GP, group practice (7), rural area)

Conversely, there was a danger that patients would move into long-term sickness absence resulting in the return to employment becoming increasingly difficult.

The timing of any discussion about returning to work varied according to the motivation of the patient, the nature of their usual employment and their condition. There are five main points at which GPs may raise the issue of the return to work or to job seeking. Although indicating the general approach, which GPs take to the raising of the issue of return to work, they are not mutually exclusive and can apply in combination:

**At the commencement of certification**

Some GPs raise the issue of returning to work or to job seeking at the very first consultation, almost as if outlining the ‘rules of the game’. The likely length of certification, or the target date for return to work/job seeking will be made clear at that time.

**After a set period of time**

An alternative approach is to issue certificates for a certain period without mentioning the return to work/job seeking, but then to raise it when this period has expired. The duration of this ‘grace’ period is based on the patient’s expectation, on the GP’s estimation of the length of recovery time, or it may be a standard period of time, such as, four weeks. After this period has come to an end, the GP will review the condition and raise the issue of the return to work/job seeking.
When the condition is obviously improving

Another approach is to wait until the patient’s condition is improving before mentioning the issue of the return to work/job seeking. Some GPs will use this approach particularly for patients who are suffering from depression or psychological as opposed to physical conditions, to avoid exacerbating the condition through additional stress.

When the patient has completely recovered

An extension of this is to wait until the patient is completely better. For some GPs, this can be the preferred approach for certain types of illnesses, such as heart conditions where there is a perception of, or fear of, a high risk of recurrence of problems as a result of resuming work.

When initiated by triggers or milestones

Another possible stage for intervention is when some milestone or ‘trigger’ occurs, acting as a catalyst to raise the issue of a return to work/job seeking. These might be the receipt of results from diagnostic tests, or the end of a programme of treatment or possibly a communication from the BA or an employer.

4.2.2 Management of the sick role

The problem of patients falling into the sick role is a matter of concern to many GPs.

‘I actually use the analogy of the Devil finds work for idle hands and that is an illustration of how if you don’t have something that you get sort of satisfaction and a sense of achievement from doing, then frankly anyone’s mental health would be adversely affected. So I try and say to them how, in my own experience, and in the experience of observing a number of different individuals in different walks of life that they need, we do need the balance of work and play and I am, you know, I don’t know that I’ve ever been convinced that somebody who is on long-term sick is actually particularly happy. They’ve accepted that situation for one reason or another and sometimes I really think because that opportunity to be on the long-term sick is available that they aren’t looking as hard or as imaginatively as they could be for alternative forms of gainful employment.’

(Male, 15 years as GP, group practice (3), urban area)

‘…I mean it’s very easy, often in the early stages to make a judgement that somebody is really unfit for work and they can’t cope but as weeks and months go by you have to then really start chivvying them up to go and get back into doing their normal daily things, otherwise there is a danger that they will take on the sick role…’

(Male, 5 years as GP, group practice (4), urban area)
There is general recognition that the longer a period of sickness absence, the harder it becomes to encourage patients to return to work, and the more likely the patient is to become chronically unwell.

‘...I've tried to put it across that it’s for their benefit to work ...the longer they’re off the harder it is to get them back’

(Female, 15 years as GP, group practice (3), urban area)

GPs manage the sick role in one or more of three main ways:

Firstly, they make use of persuasion and/or warnings. These aim to convince the patient of the rationale for returning to work or to inform them of the consequences of not doing so. Employment record, job prospects, insurance or job security issues may be mentioned.

Secondly, they try to anticipate or pre-empt the advent of the sick role.

Thirdly, they take a gradual approach, in what one GP described as a ‘drip drip’ fashion, through regular reviews or goal setting.

‘...challenging the patient, there’s all sorts of techniques you can use to get them to try and see what you’re getting at and I think if I sat here and said you are stressed, you must have time off work, he’d say, oh no, I’m not. It’s a sort of parent/child relationship, isn’t there, it’s a transaction analysis...’

(Male, 4 years as GP, group practice (5), rural area)

GPs found difficulty in managing patients who use various ploys to make sure that their period of sickness certification continued. This might involve, for example, the presentation of new symptoms, or needing to await an appeal, trade union action, or an insurance claim until they could be certain it was ‘safe’ to return.

There were many occasions on which GPs needed to refer their patients to other NHS services for diagnosis, advice or treatment. These included counselling, physiotherapy, occupational therapy, specialist hospital consultants and psychiatric services. The overall picture was one of either limited availability or relatively lengthy waiting lists, although this very much depended on the patient’s condition.

Over-subscription and restricted access were particular problems where physiotherapy and counselling services were needed. GPs spoke of the frustration of the length of time of waiting lists for these two services which averaged at between three and six months, depending on the region. The doctors said that the long waiting lists for such services could extend sickness absence by several weeks and even months. Limited places also resulted in GPs being cautious and referring only the most urgent cases. It also resulted in more referrals to specialists because this was a faster way of accessing certain treatments.
Those GPs who had counselling services attached to the practice had slightly more flexibility although charges were sometimes involved for the patients. Some GPs supplied the details of private physiotherapists or counsellors for their patients to speed the process along. Where patients were in employment, GPs encouraged patients to access any service available to them in the workplace or to ask employers to pay for treatment (such as physiotherapy) in order to speed their return to work. Treating the problem within the workplace also meant communication between employer and worker was open and rehabilitation could take place with reference to the job the patient already had.

Fast-track physiotherapy was talked about by many GPs to be an extremely useful means of rehabilitating a patient. However, access to it was extremely limited due to its strict criteria for referral. Conditions specifically mentioned which allowed patients fast track access were, for example, acute strokes and chest infections.

More senior GPs commented on the change in availability of access to services, referring specifically to counselling and physiotherapy. They had seen a decreased availability of access over the last few years. Access to services in rural areas was also noted as a particular problem.

The attitude of the patient and their willingness to return to work is a crucial factor in the successful management of their return to work, although the extent to which doctors felt able or willing to coax those who showed reluctance to return varied.

Some GPs felt that it was impossible for them to change the mindset of patients who were resistant.

“I think anybody who’s been off for a certain length of time is very difficult because I think for a start they’re out of the way of working. They’ve kind of got into this whole pattern of life …and suddenly they’re seeing a doctor who’s saying, oh have you thought about working, it’s like a bolt out of the blue and I think those people are very difficult to get to go back [to work]’

(Female, 23 years as GP, group practice (2), inner city area)

However a view was also expressed that GPs can have a strong influence on patients and can help to encourage the patient to return to work/job seeking more quickly.

‘…they really don’t want to go back to work, but some decision has to be made, and they can’t keep on that indefinitely’

(Female, 23 years as GP, group practice (2), inner city area)
Patients often have their own expectations of length of sickness absence. At times, the patient’s expectation is based on experience of friends or neighbours, or founded on earlier treatment patterns. There are also more unusual situations where a patient will have an expectation that an indefinite certificate will be given to them, almost by right, with no need for an examination.

‘I mean frankly some of them are taken aback when you ask to examine them, “I’m just here for my sick note”, so you say let me examine you, see how you got on since I last – “oh, it’s just my sick note, doctor, I get a sick note for 6 months”, and when you’re new in a practice you start examining the patients...you try to get them off the sick and then you realise over the years it’s the same culture as before, I’m on the sick for once and I’m on the sick forever, what the hell do you want to examine me for?’

(Female, 30 years as GP, group practice (4), rural area)

It is difficult for a GP to encourage an early return to work/job seeking if the patient holds strong expectations of how long they should be off.

GPs found themselves particularly irritated when hospital consultants told patients the length of time that they should expect to be off. This makes it very difficult for the GP to encourage the patient back to work/job seeking at an earlier date.

The doctors felt that a high proportion of patients who have jobs when they become sick are keen to return to them as soon as they are well. This is partly for financial reasons but also because of other interests and benefits that work brings. Some people are also concerned about their job security if regular or prolonged periods of absence occur.

GPs found it more difficult to encourage or discuss a return to work if the patient was unhappy in their job. This could occur with low paid, routine work particularly where there was little difference in the income received through earnings or through benefits. Work situations where the patient was experiencing high levels of stress, or where there had been significant organisational change, or where the individual was beginning to feel a strain from the physical demands of the work were also mentioned. This was particularly a problem if their work had had some link or impact on the onset of their illness or condition. GPs tend to respond to this either by continuing certification, or suggesting to the patient that they talk to the employer, the trade union, or perhaps consider changing their job.

A number of GPs felt that a patient’s return to work could be facilitated by a gradual introduction or by some simple changes or flexibility in their workplace. On rare occasions GPs might consider getting directly involved in this by approaching an employer, or, more commonly, by encouraging the patient to do so. They might also work with the patient to resolve some workplace issues, for example by encouraging them to go to the union.
Where patients’ employers took a flexible approach to return to work, an early return could be facilitated. However, this was not always the case. A particular difficulty was that employers often wanted the patient to be one hundred per cent recovered before returning to work even though this attitude may be at odds with the Disability Discrimination Act. In some cases this may be motivated by employers’ concerns about potential litigation. However, there is a danger that the patient may slip into the sick role while awaiting total recovery.

‘… the majority of my patients have great difficulty getting lighter duties from their employer…you can’t sort of ease it back into work, they either do the whole lot or nothing at all’

(Female, 15 years as GP, group practice (3), urban area)

Employers may also be unsympathetic to patients who take sickness absence. This is particularly the case where the condition is psychological rather than physical. An extension of this is that employers may be concerned about the skills, reliability or sickness patterns of people who have had periods of sickness absence and may not be keen for them to return to work.

4.3.2 Help from occupational and rehabilitation specialists

GPs are in a difficult position in managing a patient’s return to work when it looks likely that the patient may need to consider changing their job or type of work.

‘… when you have somebody that has always done a manual job and they’ve done the All Work Test and they’ve been found generally fit but obviously they couldn’t go back to being a scaffolder or something, you know, but they would be capable to do a desk job, this might be somebody who is in their 50s and who has always done manual labouring or something, then it’s hard to get them to see that they could retrain’

(Female, 9 years as GP, group practice (7), urban area)

For some people who have a limited skills base, there may be a very narrow range of jobs which they can do, and their condition may limit these options further. It will be shown in Chapter 6 that one of the main requirements that GPs had for supporting their role in the management of sickness absence was access to occupational health services. Any experience they had of such services was largely through patients being referred to employers’ services. Generally the outcomes of such referral were thought to be beneficial, both for the patient and for managing the return to work.

4.4 Returning to jobseeking

Some GPs mentioned that counsellors can play a major role in facilitating patients’ return to work. This is because, in many cases, the patient may need a focused discussion about their personal and occupational life plans and issues. They may, for example, want to consider a career change, early retirement or other form of life re-direction. Although a number of GPs engage in these types of conversations with their patients, they are time consuming and counsellors are seen as well placed to fulfil this role.
It has already been noted that many GPs find it more difficult to manage their patients’ return to job seeking and unemployment than the return to a job.

Financial considerations were particularly significant. It was the GPs’ perception that patients would often be taking a drop in income by returning to Jobseeker’s Allowance (JSA). It was therefore difficult for GPs to reconcile this prospect with their role in facilitating the better health of their patients.11

Issues surrounding personal confidence were also significant. Such patients often felt pessimistic about their potential to find a job and very disheartened by the prospect of looking. This was particularly so if they were older, had worked in an industry where jobs were declining or if they had a long history of unemployment. In such circumstances it was hard for the GP to end a period of certification, thereby committing them to a depressing prospect of job search.

Similarly, there were patients who could be described as having problems coping with the demands of everyday life. They may, for example, be particularly negative in their outlook, lacking in self-esteem or generally very disadvantaged by difficult or personal circumstances.

‘People who don’t get back to work I would say have difficulty coping with life in general. I think probably they have difficulty coping with money and just general life stresses, you tend to find they are just less positive about everything’

(Female, 11 years as GP, group practice (7), urban area)

Patients who have been away from a working environment for a long time present particular problems for GPs. Many GPs see the task of managing a return to work for this group, as almost impossible. The ingrained attitudes and adjustment to the pattern of life and the level of income make it extremely difficult to consider the very daunting task of returning to work or to job seeking.

Some GPs felt that there are patients for whom cultural attitudes to work present apparently insurmountable problems in relation to the return to work or to job seeking. There are situations where a dependency, or benefit culture is shared by a whole community, family or alternatively it could be an individual belief system. Some examples of this are quoted below:

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11 The JSA requirement to actively seek work may improve some patient’s chances of finding work and hence increase their income.
‘It’s a culture here, they don’t do anything for themselves and need to be looked after. It’s their attitude they should live off the state as there’s no work, there’s no work here so why should we travel to get jobs…and I’m talking most against women, women will live off the sick forever, single parents…you get other benefits if you’re on the sick than on the dole and it’s also more money per se. It’s an easy option’

(Female, 30 years as GP, group practice (4), rural area)

‘They’ve kind of got into this whole pattern of life…I think it just becomes a habit then, and I think they just lose all their ambition and they just see the rest of their life as being supported’

(Female, 4 years as GP, group practice (4), inner city area)

It was in such circumstances that GPs needed other resources for their patients to turn to.

Most GPs had had no direct contact with the Jobcentre in relation to individual patients. Where they had tried to find out about possible employment options for a patient or suggested that the patients find out about possible rehabilitative programmes, the results were said to be disappointing.

Some GPs were aware of, and had sometimes referred patients to, the Employment Service’s Disability Service. Referral to a Disability Employment Adviser (DEA), formerly known as Disabled Resettlement Office (DRO) can be made by a GP, either by adding a comment to the notes section of the Med 3 or by writing to the local Jobcentre. It was evident that GPs rarely did this, either because they had lost faith in doing so from an earlier experience, or because they had had very unfavourable reports about the Service from their patients or because they were not aware that this was possible. Certainly it seems that many of the experiences they had had were not particularly recent. Only one GP spontaneously mentioned using the Service recently with evident success.

Some GPs stressed the potential use of the Disability Service and felt that its role should be developed. There was also widespread support for better rehabilitation services, although not necessarily based in the Employment Service. This is further discussed in Chapter 6.

Some GPs had a general awareness of New Deal for Disabled People although knew little about the detail of what it offered. Largely because of this, it was not mentioned as part of any solution which GPs identified to help their patients return to work.
The value of a gradual re-introduction to the workplace is considered by some GPs for those who have a job. There is also a possibility of therapeutic work, which those on incapacity benefits can undertake to aid their return to employment. This had rarely been used or recommended by GPs and was virtually never mentioned spontaneously. GPs also appeared very unclear about the terms under which therapeutic work could be undertaken, if they knew of its existence at all. For example, there were concerns about whether patients would lose benefits if they engaged in therapeutic or voluntary work while they were receiving Incapacity Benefit.

4.5 The role of clinical guidelines

GPs were asked for their views about the value of clinical guidelines, particularly in the context of managing a patient’s return to work. Views about their use for these purposes were very much affected by perspectives on the value of clinical guidelines more generally.

One very clear view was that there were now far too many guidelines. Referred to as ‘guideline-itis’, GPs spoke about how inundated with guidelines they were. There was not time to read them from beginning to end and it was felt hard to prioritise which ones to read. It was thought that the large quantity of guidelines detracted from their potential use and undermined the value of the good ones.

Some GPs saw value in guidelines which referred to specific clinical conditions, for example heart failure in diabetics. This was because they provide a valuable source of update in new medication and forms of treatment.

Other GPs thought guidelines were limited in their value because they focused too much on the condition out of context of the patient. The fact that every individual and condition is unique, it was said, means that guidelines are restricted in their use

‘No two people are going to have the same condition, don’t see how a sheet of A4 can cover that’

(Male, 5 years as a GP, group practice (3), inner city area)

There was a common feeling that experience as a GP made up for the need for guidelines, and more senior GPs felt guidelines could offer them nothing new. They thought their own experience and knowledge offered more than any guidelines could. It was also felt that guidelines often repeated themselves and were therefore unnecessary and time wasting.

The Royal College of General Practitioners guidelines on low back pain (which are specifically referred to in the DWP certification guidance) were used in interviews with GPs as an example when discussing the GPs’ views about the value of guidelines in managing a return to work. Low back pain was consistently referred to as a particularly difficult condition to manage because of its undefined nature and the difficulty of
getting any 'objective' assessments. In this context, the back pain guidelines were said to be useful because they give some structure, both for the GP and for the patient, to the possible timing of recovery.

Guidelines were also felt to be useful as concrete evidence for the patient that many other patients face a similar condition and situation. Guidelines like those on back pain also provide GPs with a document which they can use as evidence to illustrate to patients that there is an approved path for treatment. In this way guidelines could assist the GP in their strategy to aid the patient’s return to work by both heightening patient motivation and giving them encouragement.

‘They give you armour, a sort of weapon to show to the patient if their progress is slow’
(Male, 22 years as a GP, group practice (4), urban area)

‘Helps to show them something in black and white’
(Male, 7 years as a GP, sole practitioner, inner city area)

The guidelines also served to reassure the GPs in their decision and give them ‘back up’ in their personal efforts to aid the patient’s return to work.

Some GPs felt guidelines to be useful for newly registered GPs, even if not for themselves, particularly ‘if done in the right way’. There was nevertheless a strong and recurrent view that guidelines formed a distraction from the real issues that needed to be addressed in aiding patients’ return to work. These included the need for more rapid access to services and specialists, more rehabilitative services and more resources for specialist advice.
There are a number of circumstances in which doctors are asked to provide medical statements to support a claim of incapacity for work or self support for their patients. Those of particular relevance to this study are the statements provided in the first six months of incapacity in order for people to receive employee sickness benefits or Statutory Sick Pay for those in employment; or Income Support or Incapacity Benefit for those currently without employment. This chapter considers the GPs’ use of, and views about, the forms and statements they have to complete and the procedures that surround certification. It also considers the nature of the contact that GPs have with the two main agents to whom the information is supplied, the Department for Work and Pensions Benefits Agency and employers.

There is a series of forms that GPs use to record the advice which they give to patients about fitness for work. These are the:

- **Med 3** which is the main form used on which the certifying doctor records the advice they have given to the patient – the form is given to the patient who may then use it as medical evidence to give to an employer or the Benefits Agency as appropriate. The form allows the doctor to record the diagnosis of the disorder causing absence from work and the recommended period of absence.

- **Med 4** which is issued on request to the patient at the time the Personal Capability Assessment is first applied which, in most cases happens after 28 weeks of incapacity. The form allows the doctor to record brief details of all the diagnosed conditions and the disability present.

- **Med 5** which is used when the GP has not examined the patient on the day of issue of the certificate but where verification of incapacity for work is required for an earlier period or on the basis of a report from another doctor.

- **Med 6** which is used to supply the Benefits Agency Medical Officer with further information about a diagnosis. These are used when the doctor feels that either the patient and/or the employer should not know the true diagnosis and hence a non-specific diagnosis is recorded on the Med 3.

Copies of these forms are shown in Appendix D.
In addition to these medical certificates, which GPs hold in their surgeries in ‘pads’, in certain cases doctors may be asked to complete a factual report for a Medical Officer of the Benefits Agency on patients to whom they have issued a certificate and who are now claiming a state incapacity. The report is completed on form IB113 and asks for factual information about the patient’s diagnosis, medical condition and prognosis (see Appendix D). Completion of this report, like the medical certificates above, is a requirement for NHS GPs under their terms of service.

5.1.2 GPs’ views about the forms and their completion

When the doctors discussed completion of the various forms and their views about them, three features were very evident:

- there was a general dislike of form filling of any kind which was seen as burdensome and an activity that had to be fitted in around everything else, often in the doctor’s ‘spare time’;
- with the exception of the Med 3, which was clearly and regularly referred to, there was some confusion about which forms were used for which purposes and when their use came into play;
- there was an evident lack of knowledge about what happens to the information supplied by GPs to the Benefits Agency/DWP and how it is used in the assessment and award of benefits or even Statutory Sick Pay.

These features were said to affect both the kind of the information that GPs supply and their views about providing it.

5.1.3 Views on Med 3, 4 and 5

In general, completion of these forms was seen as relatively straightforward by the GPs. The simpler the form the better the GPs liked them, although there were some suggestions about improving the quality of information supplied on the Med 3 by more directed questioning (see Section 6.2). The specific comments made about the individual forms were as follows:

Med 3
- GPs were uncertain about what time periods can be specified and when ‘indefinite’ can be used.
- Two week restriction on specifying date of return to work can lead to additional consultation simply for a certificate.
- Very minimal in the information required.

Med 4
- Some preference for giving slightly more detail as required on the Med 4.
- Helps to make patients more aware of extent of limitations of their condition.
- Can be time consuming.
- Require details that need reference to medical records.
- Uncertainty over time periods that can be specified.
- Some GPs were confused over when to use Med 4 rather than Med 3.
• Confusion about why it is issued for short-term illness.
• Uncertainty about how much it is read.
• Lack of understanding of its purpose/use.

**Med 5**
• Difficult to complete if not seen the patient for some time.
• In relation to backdating, there was some uncertainty over when to issue this certificate.

**5.1.4 Views on Med 6**
There was no reference to the Med 6 either in terms of its use or any problems surrounding its issue.

**5.1.5 Views on IB113**
The completion of the IB113 gave rise to a lot of critical comment. Most recurrent were the views that:
• doctors were repeatedly asked to give the same information on patients whose condition was unchanged and likely to remain so;
• it took a lot of time to complete if it was done fully/properly, particularly as medical records had to be checked for certain information;
• it was difficult to know how much detail to give, particularly as a lot of detail required time;
• the questions do not provide best vehicle for describing patients’ conditions and their incapacities;
• it was not clear why certain questions were asked;
• they were difficult to complete if the patient had not been seen for a while; and
• it was unclear that anyone ever read them.

While some of these criticisms clearly reflect the fact that the doctors know relatively little about how the request for the information becomes generated or the form used, such views often lead to reluctant and, sometimes, very minimal completion.

‘The ones that are awful are the IB113s…they take up a lot of time and I find them difficult to answer…’

(Male, 4 years as GP, group practice (5), rural area)

At present GPs are remunerated for completing IB113 forms as part of their overall NHS pay but some GPs were of the view that completion of these forms would be of better quality if doctors were ‘paid’ an item of service fee per report.

There were GPs who felt the form provided opportunities to describe their patients’ conditions in more detail. Nevertheless, it was rare for there to be an explicit understanding that the nature of the information given may avoid the need for further assessment or reports or the need for their patients to be examined by Medical Services.
A number of different issues were raised surrounding the process of providing medical information for benefit purposes. Again, many of these displayed a very hazy knowledge of the system that operates and what is done with the information that doctors provide.

There is a form – RM7 – that GPs can use to ask for an assessment of incapacity by the BA earlier than might happen under normal procedures. A copy of the RM7 is in each pad of Med 3 and Med 4 forms and some GPs use these for patients whose incapacity they are uncertain about. Other GPs said they used to do so but gave up because nothing appeared to happen after they sent in the form.

Again, the difficulty for the GPs is that they do not always know what benefits their patients are on and they may therefore have requested assessment before the system for IB becomes operational. Alternatively, the patient may have been assessed but the result remains unknown to the GP. Either way, the GP is left believing that filling in the RM7 apparently achieved nothing. This is seen by the GPs as very frustrating.

‘I used to fill out the RM7 form diligently, but nobody took any notice of them so I got fed up with it…I know they didn’t take any notice of the RM7 because the patient continued to attend and nothing ever happened so that was very disheartening from my point of view’

(Male, 12 years as a GP, group practice (5), inner city area)

Some of the older GPs who were used to using an RM7 before IB was introduced particularly missed the use of the form.

A more specific point was made that the RM7 does not state a specific address to which to return it. This gave rise to some uncertainty that the form, which was felt to be of a sensitive nature, would end up in the ‘right place’.

Some of the GPs were clearly unaware of the RM7 or when to use it. In such cases, some said they used the Med 3 instead to flag uncertainty about incapacity, either by writing a comment in the box or by writing the diagnosis in a way that suggests some doubt.

There was a widespread view that some system was needed to alert the BA or Medical Services that assessment of a patient was felt to be needed before a six-month period of incapacity had elapsed. This is discussed further in Chapter 6.

GPs receive notification from the BA to inform them that their patients have been assessed as fit for work and that no more certificates should be issued during that particular spell of incapacity. Patients can also request a copy of the full details of the decision from the BA. The GPs mainly knew that they were being informed about scores on the PCA assessment although these meant very little to them. More commonly, the notification
was criticised for the fact that the information took two pages to relay and gave no indication of the basis of the decision.

5.2.3 Certificate led consultations

A major irritant surrounding certification was the need for consultations that were solely for the issue of certificates rather than any requirement for medical care or advice. GPs saw these as a waste of their very precious surgery time. There were a number of specific circumstances in which this could arise including:

- certificates lost or mislaid;
- restrictions on the issue of Med 3s when a date for the return to work is set (see Section 5.1).

5.2.4 Appeals

The doctors varied in the extent to which they were prepared to get involved in disputes or appeals about their patients' benefits. Some would not do so at all as a matter of principle. This was either because they felt the award of benefits was not part of their remit as far as patients were concerned or because they were not prepared to spend the time it involved.

In such circumstances, some GPs recommended their patients went to a Citizens' Advice Bureau (CAB) for guidance.

Other GPs had very selective involvement in appeals and disputes. They would provide support to patients, for example, where they felt the patient's circumstances were complex, where the patient's medical condition was compounded by other factors or where they felt a decision was very unjust.

‘All the ones I’ve been involved with I’ve felt there was a genuine case and usually it’s because there’s a big social or family factor that hasn’t been taken into the equation when they’ve been for their assessment’

(Male, 4 years as GP, group practice (5), rural area)

There were also some GPs who became involved in appeals fairly routinely as part of being the patient’s ‘advocate’.

5.2.5 Help with completing benefit forms

A similar range of approaches was found in the amount of help that GPs felt able to give their patients when they had requests to provide help with form completion (for example the PCA questionnaire). Although this is not part of the formal requirement of GPs, some gave a limited amount of advice or help, some told patients this was entirely a matter for them, others diverted them to other sources of help such as the CAB or perhaps the practice manager. Whatever their practice, the GPs generally wanted as little as possible to do with the administration or ‘bureaucracy’ of their patients’ benefits.
5.2.6 Issue of statements by hospital doctors and consultants

The responsibility for issuing sickness certificates rests with the ‘treating clinician’ and for patients who are receiving hospital treatment, this may well not be the GP. Some GPs were clear about this and criticised consultants and other hospital doctors for sending the patients to them for their certificates. There was also discussion of the difficulties that the issue of medical statements caused when responsibility for treatment lay elsewhere. The GPs said that they often had to issue certificates based on information given by patients even when they had had no report or contact with a hospital consultant. In such circumstances, they may have little idea how long the period of sickness absence would or should continue which made managing the return to work more difficult.

The DWP provides doctors with a guide about their role as certifying medical practitioners (A Guide for Registered Medical Practitioners, IB204, DSS 2000). A revised version of this guide was sent to GPs in April 2000, a few months before fieldwork for this study began. The letter from the Chief Medical Adviser accompanying the new Guide encouraged GPs to ‘make themselves thoroughly familiar’ with the contents of the Guide. The reason for this was explained:

‘Medical statements, such as Med 3 and Med 4, are official documents and may be used by a patient as evidence to support a claim to a financial benefit. It is therefore very important that statements are completed in accordance with the guidance in this booklet, which is based upon the relevant law’.

(IB204, DSS, 2001)

The current Guide consists of a 40-page booklet and is accompanied by a laminated desk aid briefly summarising essential certification procedures. The desk aid is reproduced in Appendix D.

5.4 Use of the Guide

The GPs’ awareness and use of the new Guide was very variable and ranged from regular reference to it to ‘never seen it’. The most common response was a clear awareness of its existence, usually accompanied by quick read or look through soon after it was received. After that, the booklet had usually been put away for future reference ‘if there is a problem’. The desk aid had more often been kept out for regular use.

Among the few doctors who had read the Guide thoroughly, or regularly used the booklet, there were some who cited specific ways in which the information contained had been useful to them. For example, one GP said that in circumstances where she was not legally permitted to issue a sick note, she would show patients the flow diagram within the Guide to support her case. Another said he showed patients particular sections of the Guide when he wanted to prove to a stubborn patient that he was not at liberty to continue certification.
The content of the desk aid was clearly recalled by some of the GPs. With the exceptions of some GPs who had a dislike of flow charts, the desk aid had been favourably received for its ease of reference. Some GPs were using it to show patients what they could and could not do by way of certification and in some instances had given a copy to receptionists for similar purposes. (The value of aids to show to and discuss with patients is discussed in Section 6.2). Some GPs suggested that had the desk aid alone been received by GPs, rather than as part of a pack, there was a greater chance that doctors would read and digest it.

The question must be asked as to why some GPs had not read the booklet more thoroughly. Three main explanations were given:

- GPs feel inundated with written material and say they have to prioritise and be selective in what they read.
- For most GPs who saw themselves as very familiar with the day-to-day business of certification, the kind of information the booklet contains is only needed periodically so it is most useful as a reference document — ‘you only learn what you need to learn’.
- Information from the DWP, the BA or anything to do with benefits has an association with too many words, too many forms, too much bureaucracy or just an ill-enjoyed part of the work.

5.4.1 Views about Medical Services assessments

It was not part of the remit for this research to explore how GPs viewed the assessments made by Medical Officers for the award of benefits. Nevertheless there was a great deal of commentary about this from the GPs. There were two main strands to the discussion. The first concerned the quality of the assessments and/or the criteria that were being used to make them. Neither of these was viewed very favourably and there were recurrent statements about the poor reputation of ‘BA doctors’ and some of the recommendations they make. But there were also GPs who felt that the assessing doctors were working within a system that had set criteria and valued, at least to an extent, the opportunity this gave to have their patients independently assessed.

5.4.2 Communication between Medical Services and GPs

The Guide informs GPs that:

‘Medical Services doctors are able to give advice to medical colleagues on certification issues (including completion of Med 4), completion of medical reports and other medical matters relating to Incapacity Benefit’.

(IB204, DSS, 2001)

A list of addresses and telephone numbers for the Medical Services Centres then follows (Appendix B).
Relatively few of the GPs had ever sought advice from Medical Services and even then on rare occasions. However in one case where someone had done so they had been extremely impressed by the result. They had been given good advice and help in approaching an employer to suggest an aid to a return to work.

It was much more usual to find that the GPs’ only communication with the BA was through forms, reports and benefit assessment notifications. In some cases the thought that they might ring for advice had never occurred to them and awareness of the list of Medical Service Centres at the back of the Guide seemed low. There was also a certain amount of resistance to the idea of phoning the Benefits Agency or the ‘BA doctors’ either because of a lack of time, because of abortive attempts in the past or because benefits were not felt to be a central part of their role as a GP. There was also some very evident mistrust of whether a discussion with a Medical Services’ doctor would prove helpful.

The GPs were divided as to whether they would like more or improved contact with Medical Services. Some said they would value better contact in order to improve their understanding of what was required from them as GPs and the basis on which the medical evidence they gave was used in assessments and decision making. Others were reluctant to have any more communication than they had already, either because they could see no value in it or because they wanted as much distance as possible between themselves and the benefits system. Suggestions for increasing communication between GPs and the BA in ways that could prove useful to the doctors are discussed in Section 6.2.

5.5 Contact with employers

When GPs issue a medical statement for patients who are currently employed, the GP is effectively providing information for the person to pass on their employer. Nevertheless, contact between GPs and their patients’ employer is generally very limited. When it occurs, it is usually instigated by the employer and often consists of a request for a report or a view about the patient’s condition and their potential to return to their usual job. GPs usually charge for reports completed for employers for such purposes.

Some of the doctors felt that contact with employers could be very beneficial for a well-planned return to work and, in exceptional cases, some GPs did contact employers about this. Contact with employers was felt, for example, to help in identifying the need for a change in the type of work undertaken or for a phased return to work. Similarly, some employers agree to pay for physiotherapy or other treatment for the patient in order to speed the return to work. All of this helped to prevent unnecessarily long absences from work.
Other GPs were very reluctant to get involved with employers, other than perhaps through an occasional written report. Some saw a potential conflict of interest in maintaining confidentiality, for example, for patients with mental health disorders. Others thought it was the patient’s responsibility to liaise with employers about job continuity or occupational change, not theirs. There were also some GPs who said that there simply was not time for GPs to engage in dialogue with employers or ‘to give free occupational health advice’.

Larger workplaces were described to be less responsive to the gradual return to work than smaller ones; yet bigger employers were also described as more willing to finance the rehabilitation of their employees privately. This was thought to be because of the long-term financial benefit of retaining the same employee once they had returned full time.

It was felt that employers were not aware of the role they could be playing in speeding up the therapeutic process and contributing to a quicker patient return to work. GPs also saw a need for employers to understand short-term certification issues and to be very clear about what is and is not allowed concerning 0-7 days illness policy.

Further discussion of how contact between GPs and employers might be enhanced appears in Section 6.1.

5.6 Education and training in certification

Statutory certification is part of the curriculum for GP Registrars leading to professional accreditation by the Joint Committee for Postgraduate Training in General Practice. However the GPs’ perception was that their education in certification practice and procedures was generally very minimal. It mainly consisted of being taken through the various certificates and forms by a GP trainer or one of the senior partners when they were a trainee. This was sometimes supplemented by reading through the Guide for Registered Medical Practitioners and in a few cases subsequently attending seminars, lectures or training days.

‘It’s a difficult one, because everyone assumes that every doctor can fill in a certificate…so nobody gets trained on filling in Med 3,4s and 5s. Your trainer just assumes you’re born with that knowledge, because it looks so simple and yet when you actually look into it it’s not as simple as it may seem.’

(GP Tutor)

‘You did probably half an hour’s talk about DHSS forms during our vocational training, that’s sort of half an hour in four years…I think most GPs would be the same.’

(Male, 5 years as a GP, group practice (5), rural area)
There were also GPs who had not taken part in any training and who had acquired knowledge entirely through experience. Informal ‘continuing education’ around medical certification took place through contact with other partners. Difficult issues surrounding certification were sometimes discussed in practice meetings or with individual partners.

The GPs who had gained knowledge about providing medical evidence as a trainee registrar were divided into two groups - those who found their initial training valuable as a lasting source of knowledge and one which they still recalled in everyday practice today; and those who had since found other methods of training more useful. The latter included a talk by a local Benefits Agency doctor, which was valued for bringing a wider understanding of certification and benefit procedures. It was felt to be useful to meet the local Benefits Agency doctor in person and hear him explain his role and the implications of medical certification within the framework of the system as a whole.

It was thought that training about certification needed to take place at postgraduate level once doctors were working in general practice. Preferred methods of learning were through talks, tutoring, literature or in-practice learning. There was general acknowledgement that existing education in providing medical evidence was not adequate and that there was a need for better understanding of the system of certification and benefits as a whole. Suggestions for improving training and learning are further discussed in Section 6.3.
One of the core aims of the research was to consider ways in which GPs might be aided or supported in their roles surrounding sickness certification and the clinical management of a return to work. It was primarily for this purpose that the five strategic groups were undertaken towards the end of the study (see Chapter 1) although a number of ideas and suggestions were also made in the individual interviews.

This final chapter reviews the recommendations and suggestions that were made by the doctors under three broad headings – occupational health and rehabilitation resources; certification procedures and practice; and guidance, training and education. It makes no attempt to assess the viability of the ideas and it will be clear that some are more thought through than others. The evidence is also presented in a way that describes the basic principles of the change required rather than formulates a specific policy solution.

There was a widespread call from both the strategic groups and the interviews with GPs, for greater help with assessing incapacity and helping patients to optimise their employment or rehabilitation potential. Although these are, in practice, two quite distinct activities, or certainly can be seen as such, they were very locked together in the GPs’ minds.

‘…a rehabilitation service where somebody who has expertise in patient medicine, be it a doctor, a nurse or a team…physiotherapists and occupational therapists and so on, at a centre you could refer people to, for example, when they have been off sick for two months….Where they would actually get advice on how they could be rehabilitated back into work…I think it would really be a new service which would actually help people get back into work – it would be an investment.’

(PCG Board member)

‘If you’re talking about within the first six months…and I perceive there are going to be difficulties getting this person back to work ….I think we should be taking a multi-faceted approach with this person which requires somebody with an occupational understanding to be involved at an early stage and I don’t have that so I’m seeking help here… again it’s a spectrum between the very simple, easy, there’s no need to involve anyone else apart from the GP…to the very complex…more an occupational return to work problem than a physical health problem…it probably does require somebody else to be involved.’

(GP Tutor)
‘...as soon as we know there is going to be a problem like this, the sooner we can take it out of this arena and move it into independent assessment the better...it’s not only the difficult patients that will be referred to be sorted out but also the people who may be in their fifties who’ve had longstanding backache, they’ve got a heavy manual job...could somebody with the occupational health skills actually do some investigation...see if there is scope for that chap to go into a different type of job within the workforce.’

(GP tutor)

The need for such a ‘service’ derives from the problems that GPs describe in judging incapacity (Chapter 3), helping patients to identify an appropriate occupational activity and effectively manage a return to work (Chapter 4). The doctors were also almost unanimous that some intervention is needed earlier than occurs at present.

As the passages above illustrate, the resource required by GPs was specified in a number of different ways but would include an assessment of the patient’s condition in order to provide a second opinion on the nature and level of incapacity plus three other facilities relating to the clinical and occupational management of the patient:

- Occupational health advice about the nature of work that could safely be undertaken with the patient’s condition.
- Advice, where needed, about any adaptations that might need to be made to the workplace or conditions of employment.
- Opportunities for employment rehabilitation where this is required.

Although there were different views about where such a service might be located, the occupational health element featured strongly. GPs were also quite consistent in wanting a system to which they could very easily refer a patient, almost as easily as issuing a certificate.

‘What I would have is a new certificate, Med 6\textsuperscript{12}, that if you feel …that this person could be rehabilitated back to what they do …which refers them to the rehabilitation centre then it’s out of your hands.’

(PCG Board member)

There was a virtually unanimous view that such a resource would be of optimum value if it was available fairly early in the sickness period (between say 8 to 14 weeks) but certainly before six months of incapacity had been experienced.

\textsuperscript{12} There is an existing Med 6 which allows GPs to send details of a patient’s condition to the BA’s Medical Officer in confidence.
It can of course be said that these resources, at least in part, are already available through both statutory services and employers’ occupational health schemes. The GPs’ experiences led them to feel that a new ‘independent’ service was required for the following reasons:

- **BA Medical Services**, which provide medical advice to inform the assessment of capacity for work for state benefit purposes, did not appear to be available to GPs as a resource prior to six months’ incapacity, was too much linked to the benefits system to be independent and made judgements that were felt to be too rigidly prescribed by specific criteria.

- **Employment Service** facilities for rehabilitation\(^{13}\) had a poor reputation with many GPs, largely based on what their patients had told them or what the GP saw as the lack of any effective solutions to patients’ employment needs. They are also (erroneously) perceived by GPs as being available only to unemployed people.

- **Statutory occupational health** services were thought to be extremely limited if not non-existent and private schemes were seen as largely restricted to large employers.

In making suggestions, no reference was made at all to opportunities offered through ONE or New Deal for Disabled People. Although it was not the purpose of this study to carry out any kind of knowledge check amongst GPs, it was evident that doctors were largely unaware of the detail of these initiatives.

### 6.1.1 Contact with employers

There was no spontaneous call amongst GPs for much greater contact with patients’ employers. This was more to do with the time that it might involve for the GP rather than any statement of its value. Indeed, the GPs who had had some contact with a patient’s employer, other than through providing written medical reports, saw potential benefit in such liaison, as was noted in Section 5.5. Nevertheless, GPs thought the important contact for employers was with the patient not with the GP.

‘even someone like myself with an occupational hat on, I wouldn’t really initiate something with the company, I’ll say to the patient, “you go and speak to your employer”…if they write to me I’ll get a fee for doing it [medical report], whereas if I take it off my back to phone the company, spend 20 or 30 minutes sorting it out…I’m not getting paid for my time.’

(GP Specialist in occupational medicine)

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\(^{13}\) The Employment Service has a Disability Service in which help or advice is available from Disability Employment Advisers (DEAs). GPs usually referred to DEAs as ‘DROs’ (Disability Resettlement Officers) or the ‘Employment Disability Service’.
Again, GPs thought there was an important role to be played by employer-based occupational health specialists. Where either they, or one of their patients, had contact with an employer’s occupational health department, this had often proved useful to the GP in helping to manage the return to work. Primarily this was because it provided advice to the patient in an area in which GPs acknowledged themselves to be weak but also because it removed what some GPs saw as ‘risk taking’ in advising patients to return to work.

As a result of experiences like these, GPs felt that more employment-based occupational health services would be useful – for them, for their patients and for the employers themselves. However, it was recognised that this was a difficult requirement for small employers. There was therefore a suggestion that occupational health services that individual employers could buy in to should be more widespread.

There was also a suggestion that there should be easier-to-use mechanisms for GPs to flag to employers that a return to work could occur quite soon if some form of phased or ‘gentle’ re-entry could be arranged. Some GPs said they would write ‘fit within limits’ on the Med 3, others suggested a tick box on the Med 3 to more easily alert employers.

6.2 Certification procedures, feedback and guidance

The suggestions that were made for changes to certification procedures were largely underpinned by the requirement for better communication between doctors, the Benefits Agency’s Medical Services and employers. Indeed there was a lot of commentary to the effect that GPs worked in a kind of vacuum with virtually no interaction between themselves and the BA, other than through forms, reports and PCA result notifications. Similarly, as was identified in Section 5.5, there was very little contact between employers and GPs.

6.2.1 Feedback from the BA

There was some conflicting evidence about the need for feedback from the BA and certainly GPs were divided in their views about what information was required. On the one hand, as we have seen (Section 5.1), GPs felt they had very little idea of what happened to the information they provided in reports to the BA, or the basis on which specific decisions surrounding the PCA were made. On the other hand there was heavy resistance to being sent any more written material and a number of critical comments about the notifications currently received (see Section 5.2).

Yet nevertheless there were calls for more feedback on the medical judgements surrounding the PCA.

‘[It’s] never communicated why they [patients] have been found fit for work and I think that’s a major flaw in the system.’

(GP Principal)
Some GPs were also of the view that they should have feedback on the information they provide in the IB113. Without this, it was said, it was difficult to know what was needed and likely that, because of views about completing these forms, GPs would write the minimum in the absence of other guidance. It was thought that occasional feedback would be the most effective way of providing training or education for future.

“I think we need a bit more direction as to what should be on that form…the forms don’t actually help us to give the DHSS the information that’s useful and relevant to our patients.”

(GP Tutor)

A further recurrent point concerned the nature of communications. It was stressed that if GPs were going to read any information sent to them by the BA then it should be brief, with its relevance to the doctor immediately apparent.

6.2.2 Med 3

Although there is quite heavy resistance from GPs to more form filling than already required, there were suggestions that the Med 3 might provide a better vehicle than at present to provide information of value to employers or the BA. Three types of information were noted:

- An indication that the patient would be able to undertake some form of work, although not their usual occupation.
- An indication that the GP wanted a second opinion of incapacity.14
- More specific details of prognosis of the condition in terms of the potential time of a return to work.

Some GPs said they could write or ‘flag’ these pieces of information on a Med 3 as it was now designed.15 However, the more significant point appeared to be that GPs often found themselves with a little more to say when they completed a Med 3 but had no obvious section in which to write it. Currently the ‘Doctor’s remarks’ section of the Med 3 is intended for this purpose.

6.2.3 Enhanced use of RM7

A specific suggestion that was made repeatedly was to enhance the use of the RM7. As discussed in Chapter 5, this form enables GPs to ask for a medical assessment of a patient earlier than it is likely to occur under normal IB control procedures. Although the Guide16 warns the GPs that ‘the Benefits Agency may be unable to take any immediate action’, this was not well understood by the doctors and they were therefore very critical that nothing appeared to happen and described, repeatedly, that

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14 This is the role of the RM7. However, GPs had concerns about the use of the RM7 (see below).

15 The Med 3 does allow GPs to flag such information.

Acknowledgements of the RM7 were rarely, if ever, received. As a consequence, two actions were required by the doctors:

- Some acknowledgement that the message has been received by the BA.
- Some intervention that will call the patient concerned in for an independent assessment of capacity for employment.\(^{17}\)

Again, in some GPs’ minds, the need for such assessment was closely linked with some rehabilitation opportunity in the same way as described in Section 6.1. But others were more concerned about setting up a better monitoring system to stop unnecessary claims for SSP and state Incapacity Benefits although they did not want to have to ‘police’ the system themselves.

6.2.4 Certification by specialists and hospital doctors

GPs quite commonly complained that they were certifying ‘in the dark’ because the patient was receiving hospital treatment and the GP had not received any reports from the consultant or hospital doctor. Some GPs felt that the requirement that the doctor who has clinical responsibility should issue certificates should be more firmly enforced.

‘...it’s really for the doctor who is treating the patient to issue certification ...in the case of orthopaedics, for example, in fractures...we don’t even get letters to say ...how they’re getting on, whether their fracture is knitting etc... I feel that should be the job of the orthopaedic surgeon to certify...’

(PCG Board member)

6.2.5 Audit of certification practice

Although some GPs were unenthusiastic about an audit of their certification practice, they were in a minority amongst the 54 GPs who took part in this qualitative study. Indeed, the more that the idea was discussed in the groups, the more favour for the idea grew. In contrast to virtually all other aspects of their work as general medical practitioners, doctors said they had never really had any checks or systematic feedback on their certification practice. It was thought that such information would pay recognition to the fact that sickness certification was seen as a central part of a GP’s role and one that had high cost consequences if incorrectly/inadequately performed. In this context, some GPs compared certification practice with prescribing practice and noted how little focus there had been on the former compared with the latter.

There were a number of suggestions about how an audit might operate but some general support around the following features:

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\(^{17}\) It is only possible for the BA to call the patient for an assessment, in response to an RM7, if the BA are already handling a claim to a state Incapacity Benefit from that patient. However, as GPs may not appreciate this, frustration can result.
• The audit would need to provide information on an individual GP basis - practice data would be too easy to dismiss as ‘someone else’s problem’.

• There would need to be sensible benchmarks against which to compare individual ‘performance’ – it was thought that although national figures would be of interest, the most useful comparisons would be across local (e.g. Health Authority or PCG/T) or socio-demographically similar areas.

• It was thought that there were a number of different features of certificates that could be monitored (e.g. number issued, number of different lengths, number continuing over six months, certified absence related to condition) although it was recognised that some of this detail would be complex to compile. The main requirement however was for information that would indicate whether the GP, relative to others, was a lenient or strict certifier and the areas in which they were generally out of line.

Some GPs suggested that an appropriately designed measure of certification practice might be used as setting quality standards for clinical governance and revalidation.

6.2.6 Guide for Registered Medical Practitioners

Throughout the discussions there were calls from GPs for information that was actually already provided in the current Guide, or in notification received from the BA. At one of the discussion groups, for example, a GP who was very familiar with the content of the Guide – and used it to ‘manage’ his patients – pointed out to others in the group that information they were asking for was already supplied. As was described in Section 5.4, it was rare to find that GPs had read the Guide, although many had briefly looked through it. There is therefore a difficult question to address as to how GPs can acquire the information they want if written material of any density is generally put aside.

Various suggestions were made as to how to overcome this problem although often with some qualification or reservation:

• Aids (of the kind that were produced in April 2000) summarising key points and with clear references as to where to get further information. Ones that also could be used to clarify procedures with patients would also be of value.

• Use of other media like videos or CD roms (although some GPs said they would be unlikely to ever use these).

• Putting material on a website that GPs could refer to when they needed it (although it was noted that a significant proportion of GPs were not ‘literate’ computer or website users).18

18 The IB204 guidance is already available on the web. However, GPs making this suggestion were unaware of this.
6.3 Training and education

It was shown in Section 5.6 that GPs said they had received virtually no training in certification practice and procedures, either at undergraduate or postgraduate level. Although a number said it was also clearly a neglected part of their training, there was no great enthusiasm to boost ‘certification’ in the formal part of their postgraduate training. As more than one GP remarked, any lecture or seminar on medical certification was not likely to be well attended as it was not a ‘sexy’ subject.

Some of the GP tutors suggested that certification and doctors’ roles surrounding social security benefits would make an ideal unit within personal training plans and that some thought should be given to ways of making such a unit appealing to doctors. It was also recommended that a Registrar’s training pack on certification should be made available.

Although certification and benefits were not seen in themselves as particularly appealing subjects to GPs, it was thought that they could be wrapped around other subjects, like stress management, rehabilitation medicine or occupational health, to get key points across:

‘it could be put in as a session with various other courses…chronic back pain would be an obvious one…the trick is to put a different hook in there and get them in by discussing clinical issues, but then put in the certification issues alongside.’

(GP tutor)

There were also suggestions to make greater use of periodicals like Pulse to provide ‘educational’ information about certification. Articles which might inform the base from which GPs operate in certifying or managing sickness absence were recommended. For example a description of the top six conditions that cause longer-term sickness absence from work and issues surrounding a return to work; or an analysis of certification patterns and how/why people come off benefits.

• E-mail or telephone helplines, direct to Medical Services, for GPs to use when they have a query.\(^{19}\)

There was a clear view among some GPs that information about certification was generally required on a ‘need to know’ basis but was not something about which they needed to have a lot of detail in their heads. For this reason, they thought that much of the information they needed about certification was really reference type material. However, it is also clear from the GP evidence that they are not always clear what they ‘need to know’ in order to go away to look it up. Some easy checklist of what information was essential and where they can find it might be beneficial.

\(^{19}\) A direct phone line service to the medical services helpdesk does already exist. However, GPs making this suggestion were unaware of this.

\(^{20}\) The DWP training pack on certification which is particularly aimed at GP Registrars has been made available to all regional deans in GP education.
This final chapter highlights some of the implications of the study findings for the development and support of the role of GPs in sickness certification. It begins by exploring the difference identified by the study, between the theory and the practice of certification, and goes on to discuss some implications of our research.

It may be worthwhile noting at the outset of this chapter that a key message from this study was a call for a mechanism for advice and referral, such as an occupational health resource. This is outlined in more detail in Chapter 5. This is an important finding of our research, as it underpins many of the issues raised throughout the report. The call for an occupational health resource to address this need is discussed further at the end of this chapter.

Official DWP guidance states that GPs should issue medical certificates only on the basis of a patient’s medical conditions and any consequent functional limitations that affect their ability to work. This research shows that while some GPs follow, or do their very best to follow this guidance, for others, their approach to judgements about certification and the return to work is influenced by a wide range of social, psychological and domestic circumstances, as well as the patient’s medical condition.

There are a number of reasons why GPs may take into account a wide range of factors. Firstly, some GPs held strong beliefs in the links between poor health and, for example, adverse social, domestic, financial or emotional circumstances. Secondly, on a more individual basis, GPs may be convinced that sickness absence is going to be best for a particular patient, even in cases where there may be little or no directly medical justification. A third reason is associated with the GP-patient relationship, and concerns that if patient expectations are not met, the relationship could be negatively affected, with possible adverse consequences for the future care of that patient. Lastly, in their position as general practitioners, GPs may find themselves taking into account a wide range of factors in clinical judgements and their approach to certification could be seen as an extension of this.

It is perhaps important to make reference to the fact that the research team which conducted the study reported here, also conducted a study published in 1993 which explored similar issues (Ritchie et al., 1993). Although the 1993 study had a different set of objectives, and although there have been policy changes since then, it is interesting to note that the findings of the two studies reveal very similar patterns and practices. Very little appears to have changed in terms of GP attitudes and practice.
in sickness certification, in almost a decade. This implies fairly deep-rooted cultural attitudes and behaviour, and also implies that these things may not be particularly amenable to change.

GPs manage their role in sickness certification in a number of ways. As described in Chapters 3 and 4, a range of approaches to certification was identified. The fact that GPs differ in their approach, not only mirrors differences in GP style more generally, but also has implications for the responses which may be most effective in providing support or encouragement to GPs in their certification role.

Clearly some initiatives will work well for some GPs and not for others. The strong commitment of some GPs to their rationale for 'lenient' certification practice, suggests that attempts to encourage significant change in behaviour from those GPs may fall on deaf ears. It may be those in the middle of the continuum, with a moderately positive, or potentially positive attitude to their certification role, who may be the most amenable to change and could respond best to initiatives which offer support, advice or training in certification.

The range of approaches which GPs take to certification can sometimes result in seemingly ad hoc or inconsistent certification practice. This, as well as being unpredictable and sometimes raising questions of equity, may also confuse patient expectations of their GP’s certification practice.

For some GPs, patient expectations and consequent concerns about the GP-patient relationship are a strong influence on certification behaviour. This may beg the question of whether a heightened awareness amongst the public of the potentially therapeutic health value of work and the potentially detrimental effects of the sick-role, could result in more appropriate certification becoming an easier task for GPs. This is however, likely to remain a theoretical question.

For many of the GPs interviewed, their role in sickness certification was at best tolerated, and at worst neglected. Although some GPs valued their role in sickness certification as part of a package of treatment for patients of working age, others saw it solely as an irritation and felt that it brought unwanted stresses, dilemmas and demands. Some GPs explained in interviews, for example, how they perceived their role in certification conflicted with the reasons and motivation behind their original decision to become a doctor. Others described certification as a part of their jobs of which they were not fond, and from which they derived much frustration and little satisfaction. Because of this, certification, and the associated time spent discussing and assessing capacity to work, was very likely to be viewed by GPs as a low priority.
The low priority accorded to certification has important implications. Firstly, it may result in more certificates being issued. This is because, as some GPs repeatedly illustrated, should there be difficulties, barriers or dilemmas in the process of judging incapacity to work, GPs are likely to issue a certificate, at least temporarily. Secondly, although GPs described feeling a lack of expertise in their certification role, at the same time, the low status accorded to certification suggests, as was indicated in this study, a low level of enthusiasm in developing expertise.

The challenge therefore is to find either a way that GPs will want to, or be able to, engage more actively with the certification process, or to change the system more radically, so that they do not need to. The Cabinet Office paper, ‘Reducing General Practitioners Paperwork’ (Cabinet Office, 2001), suggests a role for nurse practitioners in issuing sickness certificates, a proposal which is to be piloted in 2001. For some GPs, this will appear to offer a much sought after ‘way out’ of their certification role. Others may find it difficult or sub-optimal to disengage certification from the clinical management of their patients. In the context of nurse-practitioner certification, it will also be interesting to examine issues and difficulties relating to the nurse-patient relationship which are likely to arise as they have done in GP certification, albeit in a different form.

Compounding the low status accorded to certification activities, a sense was suggested by some GPs, of a ‘distance’ between themselves and the DWP and/or the BA. There was, for example, little evidence of a sense of a shared agenda to pursue their patients’ best interests. The certification and reporting process, and by extension the BA itself, was viewed by some GPs quite negatively and sometimes accompanied by a sense that the certification role was being undertaken ‘for the BA’ and that they were doing a favour for an unrelated and irrelevant agency.

Furthermore, some of the issues raised by this study suggest themselves as health, rather than benefit, issues. The potentially detrimental effect of work, or of extended sickness absence, for example, appear to be a public health, rather than benefits, concern. Likewise, considerations of GPs’ role and workload imply a role for the Department of Health, as well as for the Benefits Agency.

GPs can and do intervene in the trajectory of a patient’s sickness absence in a number of ways. They make judgements about whether or not to issue a certificate and whether or not to extend it. They decide at what point and in what way to raise with the patient the subject of returning to work after a period of sickness absence and they make referrals for treatment or diagnostic tests.
This study has highlighted the significant importance that was well recognised by GPs, of the timeliness of effective interventions. Encouraging a patient back to work or to job seeking became increasingly difficult as the period of sickness absence extended. It appeared to be important that interventions geared towards a return to work were introduced within the first three or four months, and certainly within the first six months. The onset of the sick role represented a significant risk, not only to the chance of a return to work, but also to the prospects of long-term health.

It was evident that GPs do not feel equipped to make some of the judgements they are being asked to make in certification, and that they resist making others. As a consequence, they are likely to be prolonging sickness absence rather than facilitating a return to work. As is evident, this is likely to increase the numbers who become excluded from opportunities of regular employment because of long-term or permanent sickness.

The suggestion to establish an occupational health resource, to which GPs can refer certain patients at a reasonably early stage of their sickness absence, was by far the most recurrent and widely supported solution offered. Not only would this help GPs greatly with the more difficult side of their certification role, it might also help to raise the profile of this element of their work.

'what I would wish to see would be more of a rehabilitation service where somebody who has expertise, be it... therapists, physiotherapists and occupation therapists and so on... somewhere where you could refer people to when they've been off sick for two months. ... they would actually get advice on how they could be rehabilitated back into work...'

(PCG board member)

Many of the other suggestions would work in tandem with an expert resource of this kind but also help to confirm the importance of the GP's role in sickness certification. In particular, better education about the implications of good certification practice, fuller communication with the BA about the information provided for benefit purposes and some modifications to aid the process of certification would serve such confirmation well.
GPs were selected to provide a range of characteristics, in terms of length of time in general practice, whether they were working full or part time as GPs, and whether or not they had a special interest in occupational health. Data was gathered from a total of 54 GPs, 33 who were interviewed individually and 21 who took part in the strategic groups.

Of the 54 GPs who were respondents in the study, 38 were men and 16 were women. Eleven of the GPs were from ethnic minority communities.

Of those interviewed individually\(^2\), just under half had been practising for 10 years or less and around a third had been a GP for over 20 years (Table 3.1).

**Table A.1 Number of years in general practice**

<table>
<thead>
<tr>
<th>Depth interviews</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>7</td>
</tr>
<tr>
<td>6-10 years</td>
<td>8</td>
</tr>
<tr>
<td>11-20 years</td>
<td>6</td>
</tr>
<tr>
<td>21-30 years</td>
<td>10</td>
</tr>
<tr>
<td>Over 30 years</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

Thirteen were senior partners, which included single-handed GPs (six) as well as group practices. Six of the GPs worked part time only. An attempt was made to include in the sample some GPs who had a specialism in occupational health. Of the 54 who participated, four described themselves as having an interest in occupational health.

**A.1 The practices**

The practices were chosen to reflect a range in terms of characteristics considered important to the study, in particular, catchment area and size of practice.

The practices were located in 13 geographical areas of the Great Britain - two in Scotland, two in Wales and nine in England. These study areas were chosen to offer geographical spread and regional diversity and can be divided into three main types of catchment areas, as indicated in Table A.2.

---

\(^2\) In the strategic groups, GPs gave a brief profile of themselves but were not asked systematically for personal information. Because of the criteria for selection however, the majority were longer serving GPs.
Table A.2 Practice catchment area

<table>
<thead>
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<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Inner city / large city</td>
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<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Urban / suburban</td>
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<td>14</td>
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</tr>
<tr>
<td>Rural</td>
<td>9</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>21</td>
<td>54</td>
</tr>
</tbody>
</table>

It was important for the study to cover a range of areas in terms of the socio-economic deprivation and unemployment levels in their practice catchment area as this was likely to have a bearing on issues surrounding sickness certification for the GPs practising there. Deprivation and unemployment scores were developed for each practice by postcode, taken from the 1991 census data and a range of practices selected.

Table A.3 Levels of unemployment in practice catchment area

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<tr>
<td>Medium</td>
<td>15</td>
</tr>
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<td>High</td>
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</tr>
<tr>
<td>Total</td>
<td>33</td>
</tr>
</tbody>
</table>

An attempt was also made to include diversity in terms of size of practices selected. This was achieved by including a range of practice list sizes with different numbers of GPs (Table A.4)

Table A.4 Number of partners in practice

<table>
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<tbody>
<tr>
<td>Single handed</td>
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<tr>
<td>2-3</td>
<td>10</td>
</tr>
<tr>
<td>4-6</td>
<td>13</td>
</tr>
<tr>
<td>7 and over</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
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Table A.5 Total list size of practice

<table>
<thead>
<tr>
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<tr>
<td>4,999 and under</td>
<td>10</td>
</tr>
<tr>
<td>5,000–9,999</td>
<td>19</td>
</tr>
<tr>
<td>10,000 – 14,999</td>
<td>2</td>
</tr>
<tr>
<td>15,000 and over</td>
<td>1</td>
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<tr>
<td>Not known</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
</tr>
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APPENDIX B  ADVICE AND GUIDANCE FOR CERTIFYING MEDICAL PRACTITIONERS

The Department for Work and Pensions issues guidance on sickness certification to all NHS GPs and other senior clinicians who have direct patient contact [IB204 Medical Evidence for Statutory Sick Pay and Social Security Incapacity Benefit purposes – A Guide for Registered Medical Practitioners, pub April 2000]. Further copies can be obtained from the local Benefits Agency office and the text can be found at the DWP web site: www.dss.gov.uk/publications/dss/2000/medical/index.htm

The Benefits Agency obtain medical advice, under contract, from doctors employed by Medical Services provided by SEMA Group. Medical Services doctors are able to give telephone advice to medical colleagues on certification issues, completion of medical reports and other medical matters relating to state Incapacity Benefit. Medical Services’ doctors are only able to offer general advice and will not be able to discuss individual cases which are being assessed for the benefit. This service is offered to those medical practitioners providing medical certificates/reports and therefore the telephone numbers should not be passed to patients.

Other general enquiries on benefit related issues should, in the first instance, be directed to the local Benefits Agency office.

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<tr>
<td>Glasgow MSc</td>
</tr>
<tr>
<td>Corunna House</td>
</tr>
<tr>
<td>29 Cadogan Street</td>
</tr>
<tr>
<td>Glasgow G2 7RD</td>
</tr>
<tr>
<td>Tel: 0141 249 3714</td>
</tr>
<tr>
<td>Cardiff MSc</td>
</tr>
<tr>
<td>Block 1</td>
</tr>
<tr>
<td>Government Buildings</td>
</tr>
<tr>
<td>Gabalfa, Cardiff CF4 4YF</td>
</tr>
<tr>
<td>Tel: 029 2058 6750</td>
</tr>
<tr>
<td>Bristol MSC</td>
</tr>
<tr>
<td>Government Buildings</td>
</tr>
<tr>
<td>Flowers Hill</td>
</tr>
<tr>
<td>Bristol BS4 5LA</td>
</tr>
<tr>
<td>Tel: 0117 971 8382</td>
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<tr>
<td>Newcastle MSC</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Arden House</td>
</tr>
<tr>
<td>Regent Centre</td>
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<tr>
<td>Gosforth</td>
</tr>
<tr>
<td>Newcastle NE3 3JN</td>
</tr>
<tr>
<td>Tel: 0191 223 3110</td>
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<tr>
<td>Sutton MSC</td>
</tr>
<tr>
<td>Sutherland House</td>
</tr>
<tr>
<td>29/35 Brighton Road</td>
</tr>
<tr>
<td>Sutton</td>
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<tr>
<td>SM2 5AN</td>
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<tr>
<td>Tel: 020 8652 6447</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Bootle MSC</td>
</tr>
<tr>
<td>St Martin House</td>
</tr>
<tr>
<td>Stanley Precinct</td>
</tr>
<tr>
<td>Bootle</td>
</tr>
<tr>
<td>Merseyside L69 9BN</td>
</tr>
<tr>
<td>Tel: 0151 934 6070</td>
</tr>
</tbody>
</table>
Dear Dr { } 

DSS research into medical certification

I am writing to ask for your help with a study of medical certification for Statutory Sick Pay and sickness benefits that is currently being undertaken by this Department. We are interested to know more about the roles played by General Practitioners when advising patients about their fitness for work and how these roles are viewed. The research will be used to inform the design of policies, guidance and training for medical practitioners.

We have asked the National Centre for Social Research, an independent research institute, to carry out the study on our behalf. Their work will include interviews with GPs in eight areas of the country. One of these is the area in which your practice is located. The sample for the research has been carefully selected to represent different types of practices, in terms of size and catchment area, and to include GPs with different levels of seniority. You have been selected to take part and we would therefore be most grateful if you would agree to be interviewed.

If you are willing to do this, a researcher from the National Centre will come to talk to you at your practice. The interview will take approximately one hour and the National Centre will be paying an honorarium of £70 in appreciation of the time you give. The interviews will be taking place in late June and July and the research team will contact you directly to arrange a convenient time to meet with you.

All the information you give will be treated in the strictest confidence by the National Centre for Social Research. The evidence collected will be presented in a form from which neither your practice, nor your patients, could be identified.

If you are willing to be interviewed, you need do nothing. The researchers will contact you at the appropriate time. If you would like to know more about the study, or have any concerns about taking part, then please do not hesitate to contact Dr Nick Niven-Jenkins in this office (020 7962 8045). If, however, you do not want to take part it would help us if you could let Dr Niven-Jenkins know by [two weeks after date of letter] and you will not be troubled further.

I do hope you will be able to help us with this important research.

Yours sincerely

Dr Mansel Aylward
Chief Medical Adviser
1. Background
The practice
- Number of GPs/list size
- Characteristics of practice catchment area
  - socio economic
  - levels of unemployment
  - other characteristics that define practice population (e.g. dominant groups of conditions)
- Services/facilities available at practice
- Whether Primary Care Group has any special interests

2. The GP
- Number of years as GP
- Length of time in this practice
- Full time or part time
- Any special interests in occupational health/rehabilitative services

II. Medical Certification
3. Issuing Medical Statements
- Issues raised
- We now want to talk about issuing medical statements. Very broadly, what issues does it raise for you?

4. Judging incapacity
(important)
- What factors are taken into account when judging incapacity for work (either short term or long term)?
- What most influences their judgements?
- Which groups/circumstances cause most difficulty in assessing incapacity?
- Patient expectation/viewpoint
  - What expectations do patients have about length of statements; how do they deal with these?
  - How do they pick up the patient’s viewpoint/expectation?
  - How do they deal with/respond to that?

5. Example Case Illustration
(Recent case: Under 28 weeks. A case which they think is likely to involve an extended period of certification)

6. Managing a return to work
(ask for examples)
- Stage at which begin to talk about a return to work (or to looking for work if unemployed)
- In what circumstances?
- What form do discussions take?
- how do patients respond?
- Are there critical points?

III. External support and guidance
Procedures,
7. External liaison
(re: certifying and return to work)
Access to/knowledge of other services available locally to help with return to work (probe: occupational or rehabilitative services)
- Contacts with psychotherapists?
- Do they have contact with patients’ employers; over what kinds of issues; effectiveness of?
- Are there circumstances where contact with employers would be useful; what circumstances; what prevents it?
- Any direct contact with Benefits Agency/local Jobcentre?
- Awareness of clinical guidelines for management of particular conditions (e.g. low back pain); value of; potential for more

8. Current procedures and systems
- Familiarity with forms/procedures surrounding medical evidence for SPP incapacity benefits
- How gained familiarity?
- Are there areas about which they would like greater understanding?
- Any problems with particular forms/statements they have to provide; how arise?
- Awareness of the use of IB113 by Benefits Agency/ Medical Services doctors; approach to requests for completion?
- Awareness of assessments of patients by Medical Services doctors; how become aware; any impact on GP relationship with patient?
- Whether patients ever involve them in completion of the IB50; patient reasons, their response
- Appeals/patients challenging decisions; whether/how they get involved

9. Sources of information/guidance
- Use of IB204; how do they use it; views about it
- Other documents/information read or used
- Any training received in issue of statements/forms/procedures; views about?
- Extent to which any information/guidance sought from local Medical Services Centre; for what kind of issues; views about?
- Advice/help from colleagues
- Whether needed/sought help with individual patients/what circumstances/what happened?
10. Suggestions for change in policy or procedures
   • Any suggested improvements in procedures?
   • Further guidance/training needed – type, timing, content?
   • Any further guidance needed about managing patients sickness absence; who should provide?
   • Other suggestions
   • Would they find it useful:
     - To get feedback from BA on:
       - patients (examinations etc)?
       - the certificates they have filled in?
       - To have an audit of their certification?
       - To have any form of guide to clinical management?

Views about medical certificates/changes in GPS roles
   • If the situation was such that GPs generally did not have any role in issuing sickness certificates
     - views on that
     - implications for clinical management of patients

29 June 2000
WELCOME and INTRODUCTIONS  
5 minutes

PRESENTATION OF STAGE 1 FINDINGS  
10 minutes
A brief presentation of some of the key findings from Stage 1, covering in particular the key problems surrounding sickness certification and the different approaches used by GPs for issuing medical statements and managing a return to work.

Note: The content of the presentation is attached.

OBSERVATIONS ON THE KEY FINDINGS  
30 minutes
Views about different GP approaches
- Which are judged as ‘good practice’, main criteria
- Any comments on the nature of the problems identified
- Are some more serious than others; which, what order

DISCUSSION OF POSSIBLE SOLUTIONS  
75 minutes
Aim of solutions is to improve both
i) certification practice for sickness absence under 6 months
ii) clinical management of a return to work

There are five areas in which we want to discuss solutions and would like to deal with them in turn.

Certification practice
Managing a return to work
Procedures for certification
Feedback to GPs
Education, training and guidance for GPs

Reminder of key distinctions that need to be borne in mind
- Two different groups for whom certificates issued under 6 months
  - those in employment who receive SSP
  - those without employment receiving Income Support or Incapacity Benefit (under six months)
- Not concerned in these discussions with GPs’ roles in connection with Incapacity Benefit over 6 months or other disability benefits such as Disability Living Allowance

CERTIFICATION PRACTICE (including judging capacity/incapacity for work and issue of medical statements)
- What additional advice/information/resources do GPs need available to them to help judge capacity/incapacity for work
- How can advice/information/resources available to GPs be improved:
  - Within NHS
  - By Benefits Agency/Medical Services/benefits system
  - Through employers

MANAGING A RETURN TO WORK
- What additional advice/information/resources do GPs need to help/advice their patients to make a ‘healthy’ return to work/looking for work
- How can advice/information/resources available to GPs be improved:
  - within NHS/primary care services
  - in other statutory services (e.g. Employment Service/BA)
  - through employers
  - role for occupational health specialists

PROFESSIONAL DEVELOPMENT AND TRAINING
- How can knowledge base of GPs for this part of their work most effectively be improved?

EDUCATION, TRAINING AND GUIDANCE FOR GPs
- Education/training needed
  - form
  - coverage
  - at what stage(s)
- Additional/improved guidance
  - on certification practice, including possible desk top packages
  - on clinical management of particular conditions

SUMMING UP OF MAIN CONCLUSIONS  
5 minutes

P6006 - GPS AND SICKNESS CERTIFICATION

STRATEGIC GROUPS

DISCUSSION OUTLINE
APPENDIX E   FORMS USED BY GPS FOR MEDICAL CERTIFICATION AND REPORTING TO BA
This is to introduce my patient

Mr/Mrs/Miss ________________________
Address ____________________________ Tel No. ________________________

who needs help with an employment problem.
Will you please arrange to see my patient as soon as possible?
Brief details of the way in which they have been disabled or their employment capacity or loss of earnings are:

Signature __________________________ Date ________________________
Name (in BLOCK LETTERS) ________________
Address ____________________________ Tel No. ________________________

Business reply service
License no. PHQ10

Postage will be paid by the Department of Employment
Do not affix postage stamps if posted in Gr. Britain, Channel Islands, Northern or the Isle of Man.
Doctor's statement

Do not use this form for people claiming Statutory Sick Pay

In the doctor's opinion the patient is eligible for incapacity benefit and other state benefits under the Social Security Act 1986. Please fill in the following statement:

In confidence to ______________

Main diagnosis
(please list as precisely as possible)

Other diagnoses

Doctor's remarks
(please provide details regarding the condition, treatment and progress. Accuracy and detail will assist in the completion of this form)

To the doctor with the above details of illness and medical history, I recommend that the patient should:

☐ that you need not refrain from your usual occupation.
☐ that you should refrain from your usual occupation

for _______________ (give reason)
or until _______________.

Doctor's signature _______________ Date _______________

Stamp _______________
FOR MEDICAL PURPOSES ONLY

In confidence to

(A) I examined you on the date of

specialist

(B) I have not examined you but, on the basis of a

relevant written report from

following date

and advised you that you should either:

Return to work at:

Diagnosis of your disorder causing absence from

work Doctor’s remarks

( )

The special medical practitioners’ handbook is available

Doctor signature

(name/initials)

(Address)

I have advised you that you should return

FORM MED 5

PATIENT TO COMPLETE PARTICULARS ON REVERSE

Printed by DEP & POOOSO/PO301/698
This is your MATERNITY CERTIFICATE

Use this certificate if you want to claim
Statutory Maternity Pay (SMP)
Statutory Maternity Allowance (SMA)
Statutory Paternity Pay (SPP)
Statutory Paternity Allowance (SPA)

Before signing the certificate, please fill in your name and address below.

Full name:

Your address:

Date of birth:

Signature:

TO THE PATIENT
Please read the notes on the back of the form.

PART A

Name of patient:

Name of baby:

Date of birth:

Name of employer:

Signature of employer:

Date of birth of baby:

PART B

Name of patient:

Name of dependant:

Name of employer:

Signature of employer:

Date of birth of dependant:

Note: This certificate is for use by the employer to notify the Social Security Agency of the birth of a baby. It should be returned to them within 14 days of the birth.

If you have any questions about this certificate, please contact your local Social Security office.

SPECFICMEN
REFERENCES


## OTHER RESEARCH REPORTS AVAILABLE:

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<td>0 11 761683 4</td>
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<td>2.</td>
<td>Disability, Household Income &amp; Expenditure</td>
<td>0 11 761755 5</td>
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