# Sickness Certification

# in General Practice

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# 1. Motivation

As a GP (general practitioner) trainee I experience that making sick listing decisions is one of the most challenging tasks in practice. It can lead to controversy between GP and patient, a situation I prefer to avoid.

Sickness certification is an important part of daily practice of general practitioners in Belgium but it is a skill that is not taught to medical students. I realized that my sick leave decision making mainly is based on the patient, the context and my opinion of the severity of the disease, which is not always easy judging, regarding the little work experience I have.

In this difficult economic climate I also feel it is part of the GP's responsibility to keep patients at work. Therefore I searched literature to find information on facilitating my decision making on sickness certification and enhancing the return to work process.

In literature I found quite some information on the GP's point of view of sickness certification. I was curious to find out what the patient thinks about sickness certification so I composed a patient questionnaire.

# 2. Literature Study

## *How General Practitioners make sick listing decisions and how they can enhance the return to work process.*

## A. Introduction

In all Western countries the amount of time spent on sick leave and the number of long-term claims for disability benefits have increased dramatically over the last decades(1). On average, one in 10 patients in the UK will receive a sickness certificate each year, with the highest rates occurring around 50 years of age, in women. Mental health and musculoskeletal conditions are associated with the highest rates of certification(2)(3). However there is a large variability in sickness certification policy and hence sickness certification rates across Europe(2).

The financial burden placed on employers, insurance companies and governments is the main reason that the 20th century's sickness and disability schemes are viewed as untenable(1). The economic costs of sickness absence and unemployment associated with working age ill-health are over £100 billion a year (*in Britain*) – greater than the current annual budget for the NHS(4). There is evidence to suggest that the health of the population – and thus the workforce – will deteriorate in the coming decades. Levels of disease in the workforce will increase, partly due to lifestyle. Coupled with an ageing workforce this represents a major challenge for the economy. It will become increasingly important to emphasise that work is compatible with less than perfect health(5). But the urgency for change is also motivated by non-financial reasons. In Western countries, having a paid job on the labour market is seen as the main path towards social inclusion(1). Health inequalities result in higher sickness certification rates and higher economic costs. There is a social gradient in health – the lower a persons social position, the worse his or her health. Health inequalities result from social inequalities. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs(6). There is a need for comparable rates of certification to facilitate appropriate health and economic planning(2).

Addressing a 2008 British Medical Association conference, Waddell told delegates that a 'sickness certificate is one of the most powerful, potentially dangerous treatments in a GP's armamentarium'. He supported this view by citing a body of research demonstrating the detrimental effects on health and well-being which can follow certified work absence(7). There is a strong evidence base showing that work is generally good for physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment(8).

GP's are typically the first healthcare professionals consulted by patients who are absent from work through illness(9). Primary care physicians regard the task of sick listing as one of the most cumbersome in their practice(1)(10)(11)(12)(13). This is probably due to the vague work ability concept and the high frequency of non-medical issues(14). At the same time, patients often have expectations that they will receive a sickness certificate when they consult their GP and since the GP has the role of gatekeeper to social security benefits, there is potential for conflict between the GP and the patient(15). GP's can feel torn between the desire to 'advocate' for their patient and their legal responsibility to objectively 'judge' the patient's level of work disability(7)(16). Doctors are assumed to be too liberal in sick listing and too often give patients the benefit of the doubt. In other words the trust in doctors' judgments has come under attack(1).

There are guidelines available for GP's, patients and employers, addressing some of the misconceptions around working with health problems, but it does not appear that these guidelines are being implemented(15). GP's struggle with the 'importance' of their role and 'confidence' in managing the consultation about work and health due to a lack of knowledge and training in occupational medicine(11)(16). GP's feel ill-equipped to offer advice to their patients on remaining in or returning to work. Their training has to date not prepared them for this and, therefore, the work-related advice they do give, can be naturally cautious(4).

There is no consensus in the literature on how to define long- or short-term sickness absence. In the NICE (National Institute for health and clinical excellence) guideline, short-term sickness absence has been defined as absences from work of up to (but less than) 4 weeks, and long-term sickness absence as lasting 4 or more weeks. The criteria for qualifying for incapacity benefit have changed over time. The guideline mentions a lack of studies clearly defined as covering 'long-term sickness absence', 'short-term sickness absence' or 'recurring short- or long-term sickness absence'. This means that the Programme Development group of the NICE guideline has not always been able to produce recommendations that distinguish between these terms(17). Also in disability studies, it is argued that the categories of sickness, disability and incapacity are unclear. This is not due to undeveloped definitions and criteria as such, but is a consequence of the undefined and complex phenomena they are dealing with. Sickness, disability and incapacity constitute various human experiences, rather than well-defined clinical conditions(1). This leaves room for individual assessments among doctors and patients on the issue of sick listing and being sick listed(10).

The aim of this paper is to search literature for an answer to the following questions:

1/ Which criteria do physicians use to determine sick leave?

2/ How can physicians enhance the return to work process?

# B. Methods

## 1. Inclusion and exclusion criteria

### Types of studies

At first systematic reviews and practice guidelines were searched. Due to little evidence also other study designs were included (see Appendix 1).

### Types of participants

Working age adults on sick leave or in need of a sick note and GP's in a primary care setting was the studied population. Common disorders (non-occupational diseases) and occupational diseases were included. All articles that focus on one specific disorder, for example low back pain or depression, were excluded because this yielded too much additional information.

### Types of interventions

The intervention is the certification of sick leave by a general practitioner. No difference was made between short-term and long-term sick leave or between disability and incapacity, mainly because studies do not make a clear distinction.

### Types of outcome measures

The main outcome of interest are criteria that GP's use to determine work disability and how doctor's enhance the return to work process for patients on sick leave. We finally included several articles about barriers physicians encounter during sickness certification and attitudes of GP's towards sickness certification, because they indirectly influence the doctors decision on work disability.

## 2. Search strategy

### Databases

The search was conducted in the electronic databases MEDLINE, EMBASE, and CENTRAL from 5 years before search date (first search was conducted in November 2011) up until July 2012. Reference lists (and related articles) from included studies were checked for additional information.

### Search terms

The databases were searched using keywords that cover the domain 'general practice', 'work disability', 'return to work' and the domain 'doctor-patient relationship'.

For the Medline search via PubMed following MeSH (Medical Subject Headings) terms were used: (("Sick Leave/Classification"[Mesh]), (("Sick leave/Statistics and numerical data" [Mesh]) en (("Sick leave/trends" [Mesh]). We used the limits 'English', 'published in the last 5 years', and 'review' in the two latter searches. Other search terms that were used: 'sickness certification', 'criteria AND sick leave', 'sickness absence', and 'sick leave assessment'; the limits 'English', 'published in the last 5 years' and 'review' were applied. Also the search terms " criteria for sickness certification", "sickness certification AND doctor-patient relationship", and "fitness for work and consultation" with limits 'English' and published in the last 5 years' was used. Papers published in the last 5 years was used to limit the amount of results and to make sure our study is based on recent research. When conducting the reference lists of the found articles, we decided to include studies older than five years if the title seemed relevant to the key question.

Following the Medline search the Embase and Central database were searched.

The keywords for the domain 'general practice' are: 'general practice', 'primary care'.

The keywords for the domain 'work disability' are: 'sick leave', 'medical leave', 'sickness absenteeism', 'sickness certification', 'work disability', 'criteria for sick leave'.

The keywords for the domain 'return to work' are: 'return to work', 'rehabilitation', 'fitness for work'.

The keywords for the domain 'doctor-patient relationship' are: 'physician-patient relationship' , 'consultation'.

The filter applied for the Embase search was publication year 2008, 2009, 2010, 2011, 2012. For two of the searches the filters practice guidelines and systematic reviews as study type was used.

In the Central database no papers were found that added an additional value to the search.

## 3. Data collection and analysis

### Selection of studies and critical appraisal

Papers that were clearly not relevant to the key questions were eliminated based on their title and abstract. All reports of studies that were identified as potentially eligible were then assessed in full text to see whether they meet the inclusion criteria for the review(18).

Exclusion criteria of studies

- studies focusing on one particular disorder (for example: low back pain)

- studies concerning children or adolescents

- news articles, editorials, letters to editors

- duplicates

Inclusion criteria of studies

- full text available (in the databanks of the University of Leuven)

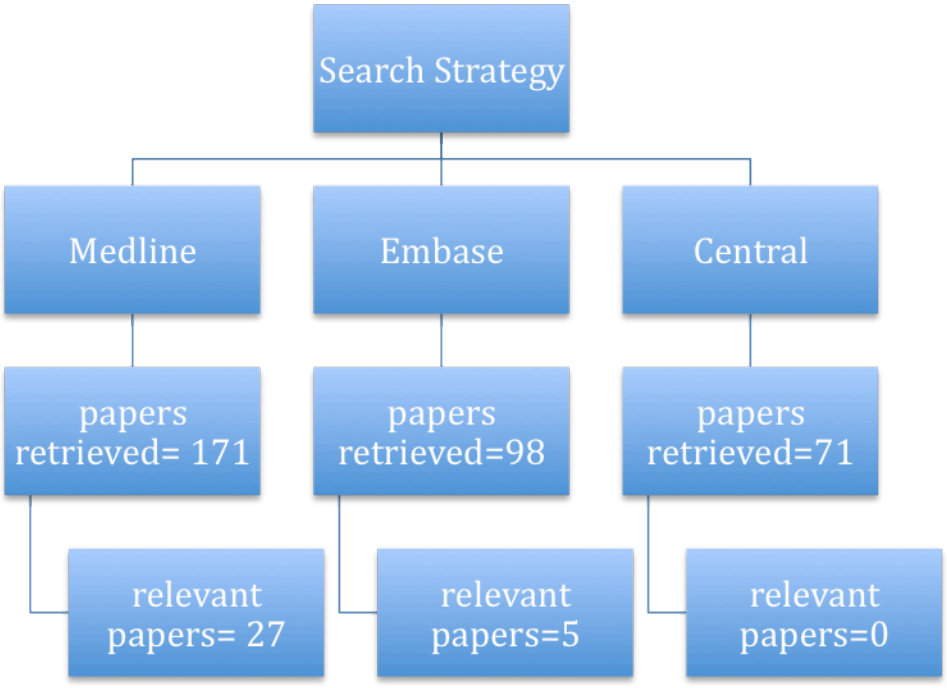
- published in English or Dutch

- primary care setting

## C. Results

The search yielded 340 papers. Finally 32 papers were found to be relevant by title or through review of the abstract. Additional papers were withheld after consulting the reference lists of the relevant articles. No Belgian papers but predominantly UK and Scandinavian papers were found.

Finally not all articles were included in the description of included studies (see Appendix 1). Though, they were used to provide sufficient information to write the introduction and the discussion of this article.



## 1. Criteria for sickness certification

### Decision making process

With the exception of low back pain, and to a lesser extent depression and anxiety disorders, there are few, if any, relevant studies with work-related outcomes, which is reflected in the content of the NHG (Nederlands Huisartsen Genootschap) guidelines(19). Likewise occupational health advice is not well integrated into the NICE (The National Institute for Health and Clinical Excellence) guidelines(20). Nevertheless, NICE did produce a public health guidance for primary care services and employers on the management of long-term sickness absence and incapacity for work(17). Also guidance from the Department of Work and Pensions is available to assist GP's in the process of sickness certification but a study shows that there is low awareness and use of these guidelines among GP's(21).

The medical disease or disablement is by law the most important criteria to determine sick leave(22)(10). A sickness certificate should outline the functional limitations that result from the medical condition only(7)(22). In practice, however, incapacity turns out to be a result of a complex assessment process in which doctors take different types of information into consideration and try to cautiously weigh the different aspects. Medical knowledge is incorporated into the process of evaluation, but does not serve as the basis of their decision in any substantive sense. Patients' experiences, their competences and social circumstances are assumed to be necessary information to judge their claims for sick leave. In this evaluation process, doctors not only assess the authenticity of the complaints, but they also consider the consequences of their evaluations for the clients' participation in the labour market in the long run(1).

Coggon and Palmer list a few simple questions that may help in a fitness for work assessment. In forming a view on the patient's potential to work a doctor needs to consider the patient's attitude and expectations towards work, the nature and demands of their job and the scope for modifications that might enable them to work despite their limitations (see Appendix 2: box 1 and 2)(23) .

The different approaches of GP's to making decisions about certification are positions on a continuum, which at one end tries to focus on the patient's condition and occupation (which accords with legal requirements) and at the other end commonly takes account of multiple factors (22). The most proactive group of doctors describes detailed discussions of work with patients and initiate contact with employers. The least proactive group of doctors describes no or limited discussions of work, either when the issue is raised by patients or when the absence is flagrantly illegitimate. In between are doctors who discuss work to some degree but who would not proceed if they met with resistance from the patient. They describe raising work so that the patient is clear about their options but feel the extent to which they could persuade or help is limited. These different approaches largely reflect the doctors' individual views about whether work is part of their remit, and about the extent of constraints on their involvement in work rehabilitation(24).

The demanding of a sickness certificate by patients is a common cause of conflict in the consultation, particularly when the patient's judgement opposes the GP's opinion(16). This results in GP's who base their decision to write a sickness certificate on the patient's wish, feeling that their role as patient advocate is of utmost importance, whereas others offer more resistance to the patients' demands through a greater understanding of issues surrounding work and health acquired through occupational health training and feel that the patients health and his/her family circumstances should be the deciding factor (16)(25).

According to an article discussing the patient's perspective in sickness certification, about a quarter of patients finds that the doctor should make the decision about being off work and that they will do whatever the doctor suggests regardless of how ill they feel. About another quarter says they could not work regardless of the doctor's opinion. The remainder of patients wants to have input in the decision about being off work but does not want to have sole responsibility for it(26).

## Indicators for sickness certification

*Patients and GP's assessment of reduced work capacity* are the strongest indicators for sickness certification. When they agreed on work incapacity, 96 percent of patients were sick listed, and when they agreed on work capacity, only 2 per cent were sick listed if assessment of degree of somatic disease and patient's presentation of symptoms were taken into consideration. When there are non-somatic causes of the work incapacity, the risk of being sick listed is increased(10).

The *GP-patient relationship*, based on mutual trust and an assumption that the doctor is acting in the patient's best interests, is a crucial consideration and will very often influence their certification practice(22)(24). GP's sometimes see a conflict in their dual role between their obligations to patients and either the benefits system or employers(24). On the contrary, patients do not feel that being questioned by their GP or discussing return to work threatens the doctor-patient relationship. Patients are very aware of abuses of the system and understand that GP's need to ensure that sick notes are genuine(26).

Difficulties with working with other *colleagues* has also been identified as a barrier to good practice, with GP's feeling undermined by secondary care colleagues, in particular those who could certify but delegated this role to the GP. A lack of collaboration from other stakeholders in particular employers, social insurance, unemployment and social welfare groups who are considered to be slow, passive and difficult to contact and either under-resourced or using resources inappropriately(16). Moreover GP's are concerned to breach patient confidentiality by disclosing illness with employers(12).

*Shortage of time* also make it difficult for doctors to address work thoroughly(24). Busy surgeries or inadequate consultation times can result in some GP's feeling that it is often easier to 'just sign' than to engage in a lengthy discussion(22). However GP's who simply give out sick notes are not necessarily giving the patient what they want(26).

Doctors highlight the difficulties in providing *continuity of care* and building up in-depth knowledge of a patient(24). Patients prefer to discuss their time off work with a GP who knows them and can place their sickness certification in the context of their illness, work and home life(26).

*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 reported to have an impact on both approach to and rates of certification(22). Long experience in family medicine increased the risk of sick leave certification and physicians working less than full time are more likely to sick list their patients(10).

## 2. Enhancing the return to work process

*The Medical Disability Advisor* provides guidelines on disability duration, and thus return to work for many diseases and injuries(27).

### The Fit note

In 2008 Black suggested that the paper-based sick note should be replaced with an electronic fit note, switching the focus from what people can't do to what they *can* do(4). The fit note reforms aimed to reduce the number of 'not fit' certificates (*the sick note)* by encouraging doctors to indicate where individuals could be supported to work with appropriate adjustments(5). A practice pointer and concise guidance on the completion of the fit note are available (see Appendix 3: box 3 and 4) (23)(28).

The fit note has helped many GP's to motivate patients to return to work and has helped some GP's adopt a stricter role with patients. However, GP's believe that there is a role for other agencies in helping remove non-medical barriers to their patients working, such as lack of skills or problems with their employers. They do not see giving specific occupational health advice to employers as part of their role(29).

While most employers support the intent behind the fit note, they believe that more should be done to deliver on its promise, with many more 'may be fit' certificates being issued(30). One reason why there are relatively few 'may be fit' certificates could be that doctors mainly have in mind the tasks and requirements of an individual's specific job when they issue a fit note. Black believes that the fit note system would be significantly strengthened if government guidance were changed to set out clearly for doctors that when issuing fit notes they should consider the individual's functional capacity to return not only to their own job, but to work in a general sense. Such an approach would help employers to make sound judgments about whether an early return to work can be facilitated, but the certifying doctor would not be required to have extensive occupational health knowledge about specific jobs and/or training.

As mentioned above, few GP's have the time available or the training to give specialised occupational advice in more complex cases. Clearly, if sickness absence rates are to be minimised, all employing organisations should have access to expert advice on whether and how an individual can be supported to

work. Black therefore recommends that the Government should fund a new Independent Assessment Service (IAS). An IAS could provide rapid and expert fitness-for-work advice about individuals on long-term sick leave or with complex health conditions. It should be provided by approved health professionals, and be appropriately quality controlled(5).

## Advising patients about work

Sickness certification is influenced by factors relating to the patients' employment including: situations where patients' work is linked to the onset of their condition, where prolonged absence has led to the adoption of the sick role, where their condition dictates a need to change type of occupation, where the employer can not offer flexibility or a gradual reintroduction to work(22), little or no economic loss in being off work, low job satisfaction or poor working conditions, the desire to escape a stressful work environment(7). Many work related variables associated with high levels of psychological ill health are potentially amenable to change. This is shown in intervention studies that have successfully improved psychological health and reduced sickness absence(31). A recent study aims to assess the effectiveness of interventions in community and workplace settings to reduce sickness absence and job loss in workers with musculoskeletal disorders. Most interventions appeared to be beneficial however most studies were small and of limited quality(32). A review suggests that flexible working conditions that increase worker control and choice are likely to have positive effect on health outcomes(33). Identifying predictors of sickness absence may help to develop effective prevention and intervention strategies to shorten the duration of disability and enhance return to work(34)(35)(36)(37).

As mentioned previously, the longer anyone is off work, the lower their chances of getting back to work. Overall, the beneficial effects of work outweigh the risks of work, and are greater than the harmful effects of being out of work(38)(39).

This evidence has important implications for advice about work. The long-term consequences of advising or agreeing that a patient should stay off work may be greater than those of the original health problem. This implies a duty to discuss with patients whether staying off work is the most appropriate management.

Common health problems - the mild/moderate mental health, musculoskeletal and cardio-respiratory conditions - make up the bulk of a GP's workload. Most common health problems are manageable: most people cope with them most of the time, and most health care is effective. The paradox is that two-thirds of certified sickness absence, long-term incapacity and ill health retirement are due to common health problems.

Many obstacles – health-related, personal/psychological, occupational/social - can get in the way of normal recovery. Many obstacles arise from myths and misunderstandings. Challenging misconceptions is one of the simplest and most effective ways of overcoming obstacles.

With common health problems, clinical management is often about managing symptoms sufficient to allow the patient to maintain or return to normal activity levels. Recovery and return to work are active processes that involve the patient's own motivation and effort. The doctor's role is reassurance, support and facilitation. Many patients find it helpful to have a return to work plan, and doctors can make an important contribution: agree realistic goals and expectations of health care, encourage incremental increase in activity levels, agree clear goals and timeline for return to work, discuss what patients can do rather than tell them what they can't, discuss how to overcome any obstacles to return to work, talk about possible sources of support to help cope with the condition.

Return to work depends on sufficient communication between doctor, patient and employer. Providing information and advice is as important as prescribing or certification.

Contact with any occupational health services (if available) may help to coordinate and facilitate return to work. Communication with employers should describe what tasks the patient can do, as well as any temporary restrictions that are medically essential(38).

# D. Discussion

## Summary of main findings

There are no Belgian guidelines regarding sickness certification. With the exception of low back pain, and to a lesser extent depression and anxiety disorders, there are few, if any, relevant studies with work-related outcomes. There is low awareness and use of the guidelines of the Department of Work and Pensions concerning sickness certification.
The medical disease or disablement is by law the most important criteria to determine sick leave. In practice, however, incapacity turns out to be a result of a complex assessment process in which doctors take the patient's experiences, competences and social circumstances into consideration.
Some GP's base their decision to write a sickness certificate on the patient's wish feeling that their role as patient advocate is of utmost importance, whereas others offer more resistance to the patients' demands through a greater understanding of issues surrounding work and health acquired through occupational health training and feel that the patients health and his/her family circumstances should be the deciding factor.
There are several factors that influence the decision making process: the GP-patient relationship, the GP-colleague relationship, patient and GP characteristics, the assessment of reduced work capacity by the patient and the GP, shortage of time, and difficulties in providing continuity of care.
In the UK, the sick note has been replaced by the fit note, trying to switch the focus to what the patient can do. GP's should advise patients on the benefits of work and should help patients outline a return to work plan.

## Strengths and limitations of the study

Firstly, the strength of this study is that it focuses on sickness absence, a domain that has not been well studied in Belgium and increasingly important in times of economic crisis. Secondly, this article gives a general overview of the existing literature concerning sick listing from a GP and patient perspective. Also practical tips on facilitating the management of sickness absence are provided.

There are several limitations to this study. First of all, analysis of the literature shows that the description and definition of "short-term and long-term sick leave" are not standardized(40). At the same time, it is unclear how to measure work ability, as it is a complex concept including physical, mental and social dimensions. Evaluation of work ability requires knowledge about the patient's work place where physicians most of the time have to rely on patient information. Definition of the work ability concept changes over time and may be influenced by health care practitioners attitudes and beliefs as well as by political decisions(14).

Secondly, because of the multifactoral nature of criteria to determine sickness certification it was difficult to construct a search strategy to cover the field. If the search strategy had focused on a specific disease (for example: low back pain or depression) then this paper maybe would have provided more practical information on how to determine the duration of sick leave for a particular illness. To fill in this gap, *The Medical Disability Advisor* was mentioned, a data source providing disease specific information on return to work.

The articles were searched and selected by only one doctor so it is more subject to bias. A quality appraisal of the papers was also not carried out because this would have required several appraisal instruments and comparison between them would have been meaningless(16).

No Belgian studies, but predominantly UK and Scandinavian papers were found. The social and insurance systems vary from Belgium. The fit note doesn't exist in Belgium but could be a helpful tool to enhance the return to work process.

## Comparison with existing literature

This study does not deliver new information on sickness certification but tries to give an overview of the existing literature concerning sickness certification.

## Implications for clinical practice and future research

There is evidence to suggest that the health of the population – and thus the workforce – will deteriorate in the coming decades. Levels of disease in the workforce will increase, due partly to lifestyle. Coupled with an ageing workforce this represents a major challenge for the economy. It will become increasingly important to emphasise that work is compatible with less than perfect health(5). Waddell concludes that

the beneficial effects of work outweigh the risks of work, and are greater than the harmful effects of long-term unemployment or prolonged sickness absence(8). Thus, the government should promote understanding of the positive relationship between work and health among employers, healthcare professionals and the general public(4).

Evidence of variable practice indicates that GP's should have more guidance and education in sickness certification(21). They need more knowledge and skills regarding how to asses work capacity, and optimal length and degree of sickness absence and information about aspects of the social insurance system(41). Nevertheless, data does suggest that GP's know more about functional assessments than they are able to tell(42). The National Education Programme in the UK, gave GP's more confidence in managing the consultation regarding work and health and GP's gave higher priority to these types of consultations after the training(43). Considering the limited access to occupational health professionals, evidence-based advice should be readily available to GP's. Occupational health professionals should participate in the development of guidelines and contribute to the formulation of recommendations on aspects of work and health(20).

In order to regain public control and to make disabled eligibility procedures more transparent, guidelines have been developed in which medical evaluations are conceptualised as formal rational decisions based on the medical condition only. However, instead of generating transparency, guidelines based on formal rationality make the complex deliberations on which doctor's judgements are based invisible, because they cover up the contextual reasoning of the evaluations. Instead of defining criteria, which will inevitably be reductionist in character, accountability procedures must involve the qualitative dimensions of the decision-making process(1).

In a recent study from Ireland GP's acknowledge that there is need for change and a review of the current sickness certification system. GPs suggested a regulated self-certification period similar to that in the UK and other European countries. GP's agree that the sickness certification practice could be improved if patients are required to register at only one practice and don't have the freedom to shop around(12).

Any potential to changing the certification system needs to focus on reducing potential for conflict, clarification of the roles of all stakeholders and improving access to specialist occupational health and rehabilitation services(16). Future research should focus on the cost-effectiveness of simple, low-cost interventions, and further explore impacts on job retention(32)(44).

## E. Conclusion

There is low awareness and use of guidelines concerning sickness certification among GP's. In practice sickness certification turns out to be a result of a complex assessment process in which doctors take different types of information into consideration. Some GP's form their own judgement of the patient's fitness for work while others rely on the patient's assessment. There are several factors that influence the

decision making process: the GP-patient relationship, the GP-colleague relationship, patient and GP characteristics, the assessment of reduced work capacity by the patient and the GP, shortage of time, and difficulties in providing continuity of care. In the UK, the sick note has been replaced by the fit note to enhance the return to work process. GP's should advise patients on the importance of work and they should help patients outline a return to work plan.

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# 3. Practice Study

## *Sickness Certification: The Patient's perspective.*

## A. Introduction

In all Western countries the amount of time spent on sick leave has increased dramatically over the last decades(1). The economic costs of sickness absence and unemployment are vast, placing a financial burden on employers, insurance companies and society(1)(2). However, it is well recognized that work is generally good for physical and mental health and well-being(3). Moreover, having a paid job on the labour market is seen as the main path towards social inclusion(4).

The purpose of a sickness certificate is to higher the threshold to stay off work and to reassure that a medical problem is under supervision of a physician. GP's are typically the first healthcare professionals consulted by patients who are absent from work through illness(5). Many studies conclude that primary care physicians regard the task of sick listing as problematic(1)(2). In the Dutch system sick listing decisions are not made by general practitioners but by occupational health physicians(2).

Several articles in the Belgian press suggest that local sickness insurance companies in Belgium (called mutualities) suggest the abolition of the sickness certificate for one day to cut down expenses in health care and to reduce the workload of general practitioners (6)(7). GP's would then be able to keep themselves busy with "more important" medical problems.

Most published studies concerning sickness certification are from Scandinavia and the UK and focus on the GP's perspective(2). We did find some research considering the patient's point of view(2)(8). There are no Belgian studies on the patient's perspective of the current sickness certification system.

The main objective of our study is to detect the patient's work situation and to find out the patient's view of sickness certification in general practice in Belgium.

## B. Methods

### 1. Setting

The study was performed by 12 GP's in four general practices in Tervuren, a village in Flanders (the Flemish-speaking part of Belgium). General practice A consists of two female doctors and one female GP trainee. General practice B consists of one male doctor and three female doctors, of which a GP trainee. General practice C consists of two doctors (one male and one female), but only the female doctor participated. General practice D consists of four doctors, two females and two males. Also 3 GPs from Wallonia (the French-speaking part of Belgium) participated. General practice E, located in Limal, consists of 1 male doctor, one female doctor (who did not participate), and a female GP trainee. General practice F, located in Bièrges, consists of one male doctor and a female GP trainee (same trainee as in Limal), working only two half days a week in this practice.

The registration period in Tervuren started on Monday the 12th of November and ended on Friday the 23rd of November. The registration period in Limal/Bièrges started on Monday the 3rd of December and ended on Friday the 14th of December.

## 2. Inclusion and exclusion criteria

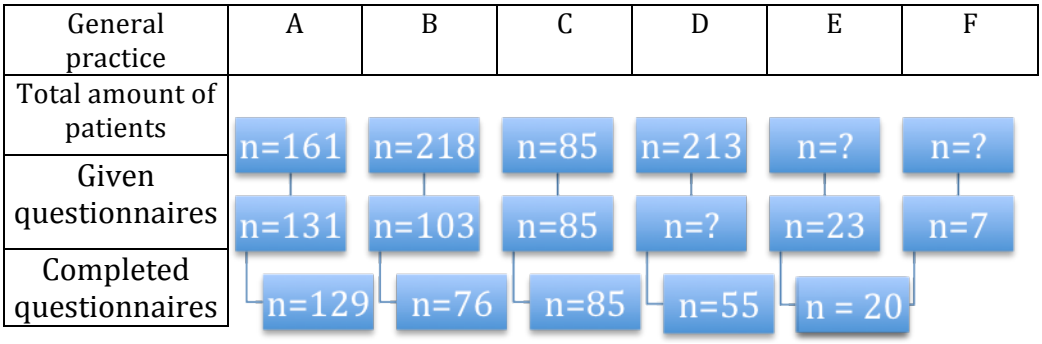
### Types of participants

Every patient between 18 and 65 years old who consulted the GP for whatever reason and were able to fill out the questionnaire were consecutively included. People under 18 years of age and above 65 years of age were excluded, considering that the largest part of this age group does not work. Also patients who consulted for a second time during the registration period and who had already filled out the questionnaire were excluded.

### Types of interventions

Participating GPs personally handed out questionnaires to their patients who consulted for whatever reason. The 15 participating GPs were asked to register all patients who consulted, the amount of patients who were given a questionnaire, and finally the amount of patients who completed a questionnaire per practice (see Figure 1). Practice E and F did not register the total amount of patients between 18 and 65 years old. Together both practices collected 20 questionnaires. Practice D did not register the amount of questionnaires they handed out to patients. Therefore it is difficult for us to judge if this sample is representative.

### Figure 1: Flow Chart




The participating general practitioners were consulted by mail and personally during an annual meeting to explain the objective of the study before they agreed to participate. After the first week of registration general practitioners were contacted by telephone to detect any problems and to get an idea of the amount of patients filling out the questionnaires.

### Types of outcome measures

The main outcome of interest is the patient's views of sickness certification within general practice consultations.

Specific aims

1. To detect the amount of patients whose employer requires a sickness certificate for one day off work.
2. To detect if patients have a possibility to do modified work if they are not fit enough to do their normal job.
3. To measure the amount of patients who would not have come to the consultation if they were not in need of a sickness certificate.
4. To find out if general practitioners discuss working conditions or other factors that may influence the length of sick leave; to find out if general practitioners give advice so patients can return to work more quickly.
5. To detect the patients opinion on the influence of the sickness certificate on the doctor-patient relationship.
6. To find out if the patient has influence on duration of sick leave that is prescribed.
7. To find out if the patient finds it a good idea to abolish the sickness certificate for 1 day off work.
8. To detect if the sickness certificate highers the threshold to stay off work (in other words: would patients stay at home more easily if they were not in need of a sickness certificate?).
9. To detect the patient's opinion on who is best placed to determine the disease status.

## 3. Data collection and analysis

A written questionnaire (Dutch, English and French version) for patients (see Appendix 4), consisting of 22 questions, was composed, because a validated questionnaire was not found in literature. However, the patient questionnaire in the article "How primary health care physicians make sick listing decisions: the impact of medical factors and functioning" van Norrmen et al. provided a good basis to compose our questions(8). Approval of the ethical committee was asked for and accepted. A pilot study with 11 randomly selected patients was performed to find out whether the questions were clear-cut and possible to answer. The time necessary to fill out the questions varied between two and five minutes.
In the patient questionnaire data sought were personal information (age, sex, education, family life, and employment status) questions concerning the patient's work situation, questions about health status, questions about expectations and outcome of the present consultation, and questions about the patient's opinion on several subjects concerning sickness certification such as the influence of the sick note on the GP-patient relationship, the patient's influence on the duration of sick leave, if the sick note should be abolished for one day, and who is best placed to assess the patient's disease status.
The data were analysed using Microsoft Excel.

## C. Results (see Appendix 5 and 6)

**Patient Information (see Questions 1 to 5)**
367 patients filled out a questionnaire of which 62% were women, 37% were men. About half of the patients are between 35 en 55 years old. 60.5% of patients has a university degree. Almost half of the patients are employees (see Figure 2).

**Figure 2: Sociodemographic Table**

| Analysis of primary outcome (n=367) | | Population | |
|---|---|---|---|
| **Sex** | Female | 228 | 62.1% |
| | Male | 136 | 37.1% |
| | No answer | 3 | 0.8% |
| **Age** | 18-25 years | 32 | 8.7% |
| | 26-35 years | 57 | 15.5% |
| | 36-45 years | 83 | 22.6% |
| | 46-55 years | 97 | 26.4% |
| | 56-65 years | 71 | 19.3% |
| | No answer | 27 | 7.4% |
| **Education** | Graduate school/University | 222 | 60.5% |
| | Upper secondary school | 95 | 25.9% |
| | Lower secondary school | 37 | 10% |
| | Primary school | 4 | 1% |
| | No education | 4 | 1% |
| | No answer | 5 | 1.4% |
| **Work Status** | Employee | 171 | 46.6% |
| | Worker | 34 | 9.3% |
| | Functionary/official/civil servant | 38 | 10.4% |
| | Self-employed | 30 | 8.2% |
| | Student | 17 | 4.6% |
| | Housewife | 20 | 5.4% |
| | Unemployed | 16 | 4.4% |
| | Other, specify... | 33 | 9% |
| | No Answer | 0 | 0% |
| | Excluded (multiple answers) | 8 | 2.2% |
| **Amount of sick days in year before present consultation** | None | 110 | 30% |
| | One week or less | 124 | 33.8% |
| | More than one week but less than four weeks | 57 | 15.5% |
| | More than four weeks but less than 3 months | 14 | 3.8% |
| | More than 3 months | 15 | 4% |
| | Not applicable | 39 | 10.6% |
| | No answer | 8 | 2.2% |

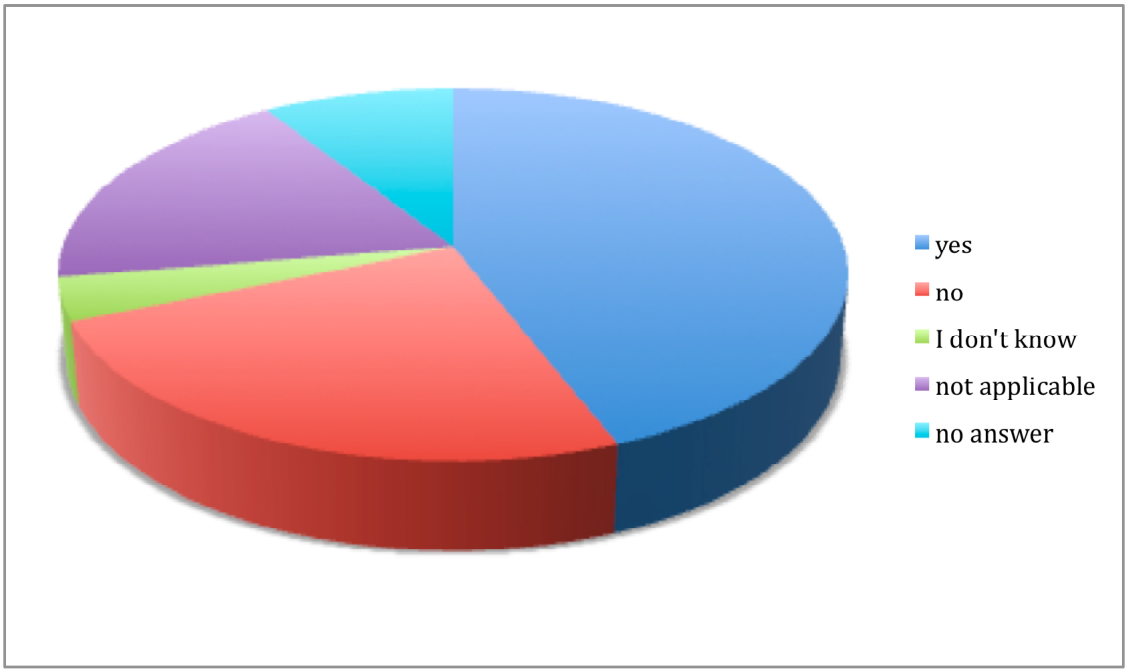
**Work situation (see Questions 6,7 and 8)**

The majority of patients do not find there is a high amount of sickness absence at their work but still about one fifth of the patients do think this is the case.

Specific aim 1: Most patients (44%) need a sickness certificate for one day off work (see Figure 3). Although, about one fourth of patients can stay home for one day or more without a sick note.

Specific aim 2: The largest part of patients (41.1%) does not have the possibility to do altered work when not fit to do their normal job. 26.2% of patients do have this possibility.

## Figure 3: My employer requires a sickness certificate if I am off work sick for 1 day




**Health status (see Questions 9 and 10)**

The majority of patients (64.3%) mention they are mostly healthy and feel well. 30% of patients have not been absent from work and 33.8% have had less than one week of sick leave in the year prior to the present consultation (see Figure 2). About 8% of patients have been on sick leave for more than four weeks, of which half more than 3 months.

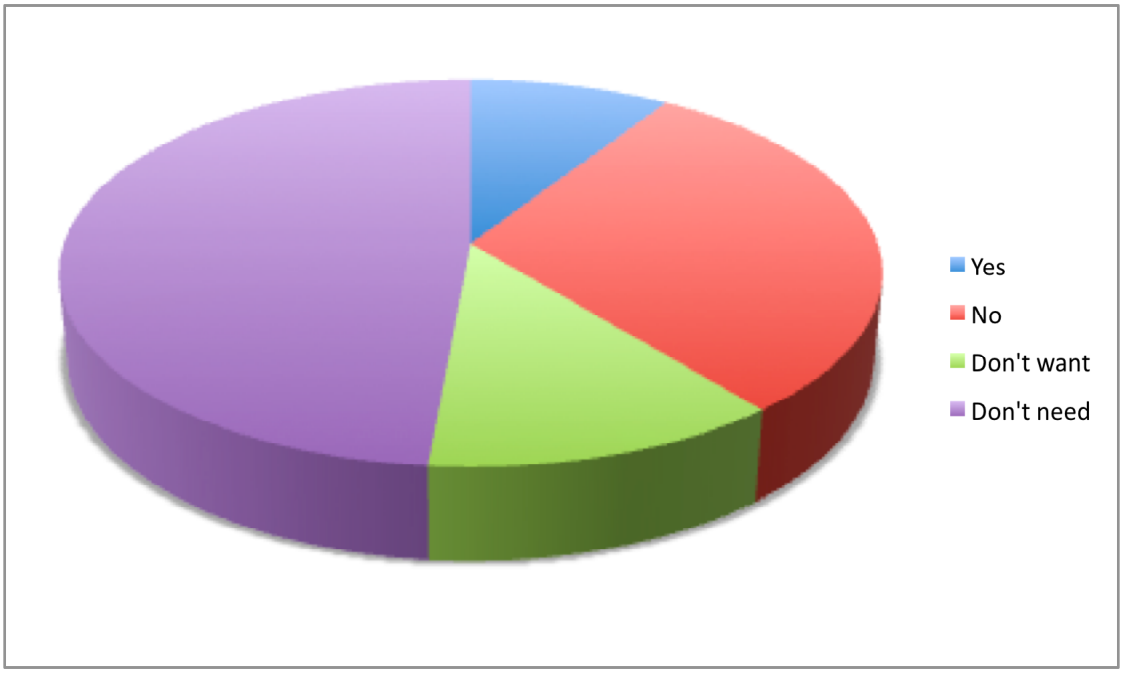
**Questions about your present consultation (see Questions 11 to 15)**

Specific aim 3: 37.3% of patients were in need of a sick note of which 8,7% would not have come to the consultation if they were not in need of a sick note but 28.6% were also seeking reassurance and/or advice (see Figure 4).

Specific aim 4: In more than half of the consultations the doctor either asked about the patient's working conditions or already knew about them. Nonetheless, in more than one fifth of the consultations the GP did not ask about working conditions. Also in about half of the consultations the doctor took other factors, which could have an influence on how the patient feels, into account or already knew about these factors.

But in more than one fourth of consultations other factors were not questioned. In most cases (272 patients or 74%) the doctor gave advice on how to recover from sickness more quickly.
The largest part of the patients thought that the results of clinical examination and/or other tests were of great importance to the doctor's decision to sick list them.

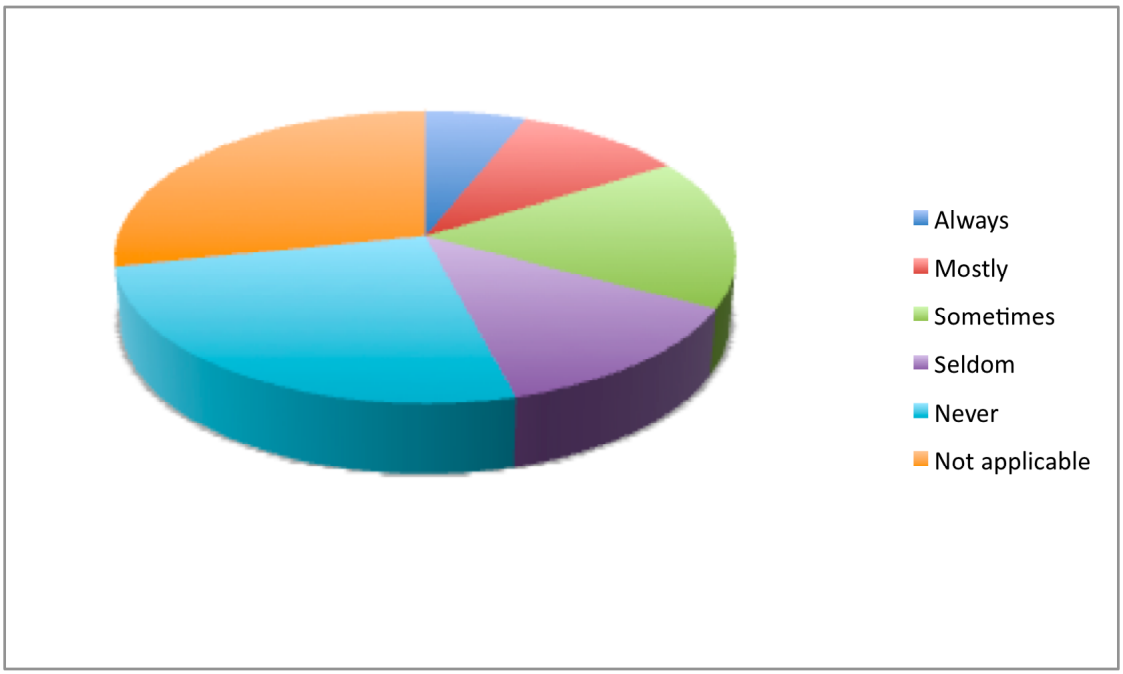
**Figure 4: The sickness certificate was my main reason for consultation today**




**Your opinion (see Questions 16 to 22)**

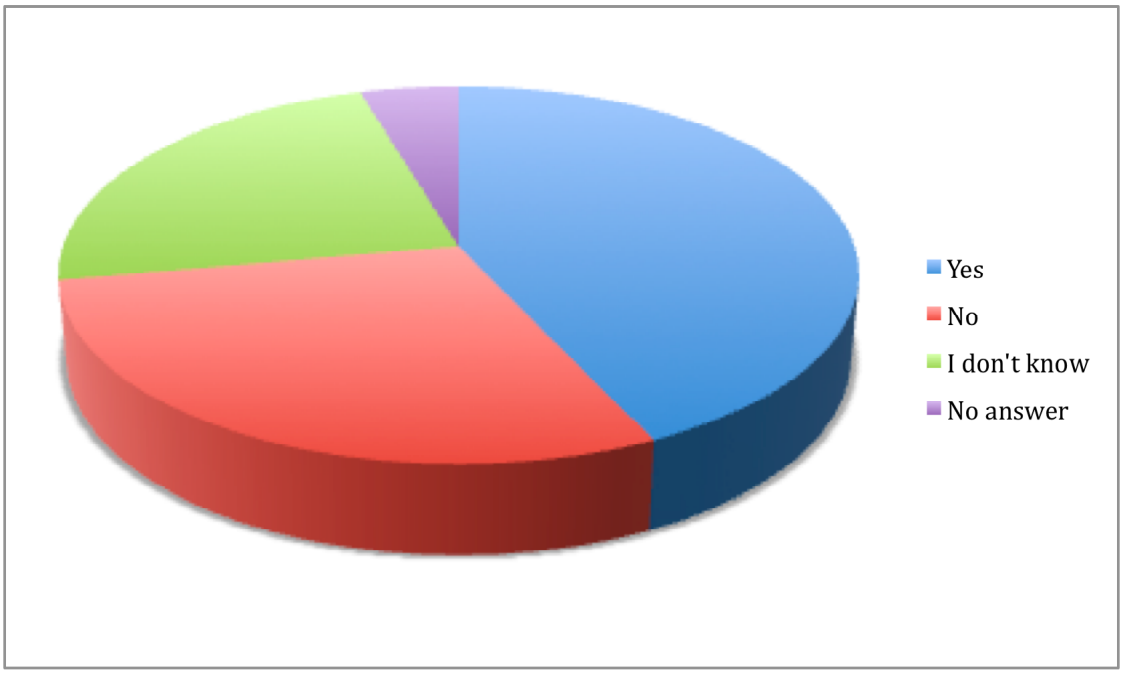
Specific aim 5: A bulk of patients (46.3%) never feels anxiety prior to a consultation in which they need to ask for a sick note. 7% of patients mostly or always feel anxiety. 61,3% of patients never feel that discussing sickness certification with their GP is a threat to the GP-patient relationship. Only about 2% of patients mostly or always find it a threat.
Specific aim 6: Most patients (26.7%) find this question (see question 18) not applicable to their situation. 24.3% of patients finds they never have influence on the duration of sick leave (see Figure 5). Nevertheless, 15.3% finds they always or mostly have influence.

**Figure 5: I can influence the duration of sick leave that is prescribed**



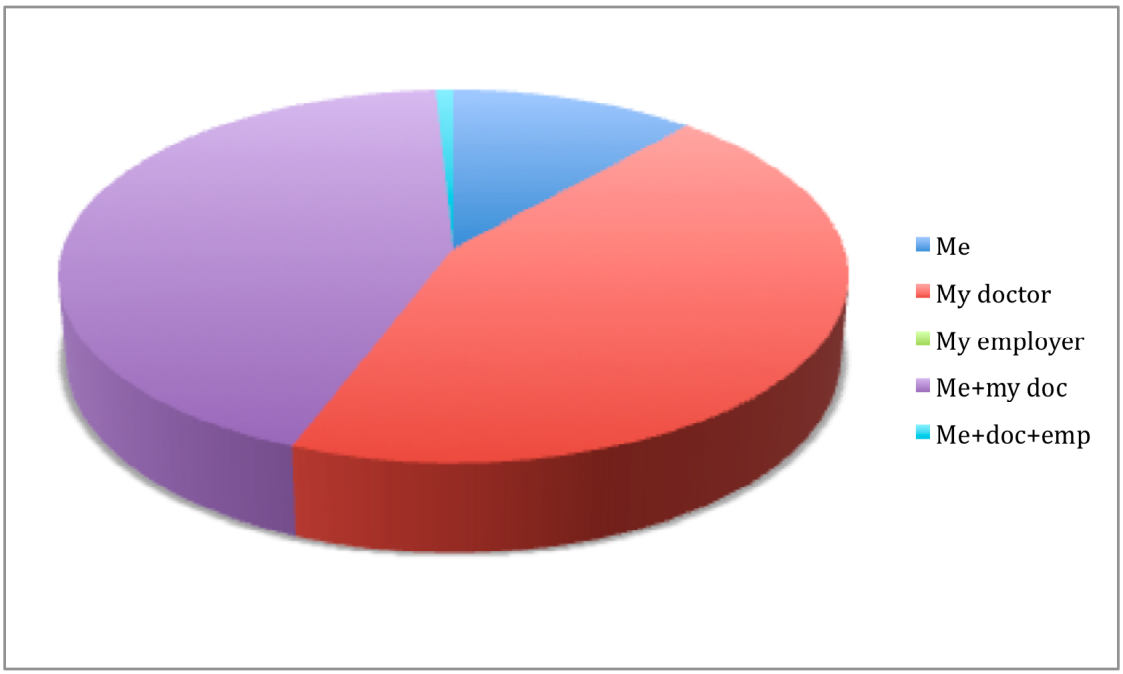

Specific Aim 7: 158 patients (43%) find it a good idea to abolish the sickness certificate for one day, 107 patients (29.2%) do not think this is a good idea and 85 patients (23.2%) have no opinion (see Figure 6).

**Figure 6: I think it is a good idea to abolish the sickness certificate for one day off work**



Specific Aim 8: The best part of patients does not find that the sick note highers the threshold to stay home from work. In other words this could mean that patients would not stay home more easily if they were not in need of a sick note.
251 patients (68.3%) find it a good thing that social insurance officers make home visits to ensure that there is no cheating with sickness certification.
Specific Aim 9: About 40% of patients find that the doctor is best placed to estimate their disease status. About just as many patients find that they themselves *and* the doctor can best predict how sick they are (see Figure 7).

**Figure 7: Who is best placed to assess your disease status?**




# D. Discussion

## Summary of main findings

Most patients are required to have a sickness certificate if they are off sick for one day and most of them do not have the possibility to do altered work when not fit to do their normal job. When patients consult for a sickness certificate they seldom come only for the sick note but also want reassurance and/or advice. In more than half of the consultations the GP asks about the patient's working conditions or already knows about them. A majority of patients has no anxiety to discuss sickness certification with their GP and do not consider these discussions as a threat to the GP-patient relationship. The patient's view on their influence on the duration of sick leave is divergent, with more than one third finding they seldom or never have influence. Most patients find it a good idea to abolish the sickness certificate for one day but still about 30% of patients do not find this a good idea. Patients claim they don't think that the sick note

highers the threshold to stay off work. And finally, the patient finds the doctor best-placed to assess their disease status.

## Strengths and limitations of the study

There are several strengths to this study. First of all, like mentioned before, there are no Belgian studies on the patient's perspective of sickness certification. Secondly, we find the response rate quite high, collecting 367 questionnaires in two weeks. Thirdly, we were able to draw some surprising conclusions that contradict with what GPs sometimes feel in practice. For example, most patients feel that discussing sickness certification is not a threat to the GP-patient relationship. This opposes to what GP's often assume (2). We also expected that all patients would agree to abolish the sickness certificate for one day but surprisingly enough, almost 30% of patients do not think this is a good idea.

There are also several limitations to this study. Foremost, a validated questionnaire was not found in literature. Secondly, we assume that several questions were not well interpreted by the patients. For example, we think that question 14 was not well understood due to the high amount of missing answers and "not applicable" as answer. Many questions were also not relevant for non-working patients (students, housewives, retired or unemployed) or self-employed patients because they are never in need of a sickness certificate. This probably added to the amount of blank answers and "not applicable" as answer. Thirdly, the patient population may not reflect the average population, seeing most patients live in Tervuren, a village in Flanders and are highly educated. Another limitation of the study is the registration period. If the registration period had taken place during, for example the "influenza season", there would have been many more sick notes certified. The registration period was also quite short.

## Comparison with existing literature and implications for clinical practice and future research

This research teaches us several things that can have implications on clinical practice. First of all, still one fifth of patients find there is a high amount of sickness absence at their work. We believe this emphasizes the importance of creating healthy work environments, assuming that a healthy work environment creates healthy workers.

Also when writing a sick note, we believe the GP should always consider if the patient can do altered work, when not fit to do his normal job. In the UK the fit note is an effort to reduce sickness absence by focusing on what the patient still can do(9). 26.2% of the patients who filled out our questionnaire answered they have the possibility to do altered work. This opposes to our experience in daily practice, where the patient practically always appears not to have this possibility.

GP's are not necessarily giving the patients what they want, by just handing out sick notes(2). Our survey confirms that the majority of patients also want reassurance and/or advice. When advising on fitness for

work, doctors should consider any evidence- or consensus-based guidelines on return to work for the condition(9). Though, evidence of variable practice indicates that GP's should have more guidance and education in occupational health(10). Also the role of employers, GP's, occupational health services, and local health insurances (called mutualities) in sickness certification should be better clarified(11). According to a recent OECD *(Organisation for Economic Co-operation and Development)*-report on *Mental Health and Work in Belgium*, the institutional set-up in Belgium has great potential in addressing the challenges of mental ill-health and work but the current system is poorly implemented(12).

It is important to remind GP's to ask patients about working conditions and others factors that might have influence on the reason or duration of sick leave. When writing a sick note, doctors should be aware of the fact that work is generally good for health and well-being and that prolonged periods off work can lead to slower recovery(9)(13).

Very little patients find that discussing sickness certification is a threat to the GP-patient relationship. This opposes to what GPs often assume(2).

Only 15% of patients who filled out the questionnaire feels they mostly or always have influence on the duration of sick leave. According to literature, the experience of most patients is that the doctor determines the length of time on the certificate(2). We believe this should be prescribed by shared decision-making early on in the illness.

We expected that all patients would want to abolish the sickness certificate for one day but still about one third of patients do not find this is a good idea.

A clear majority of patients does not think that the sickness certificate highers the threshold to stay off work. Does this mean that patients claim they would not stay at home more easily if they were not in need of a sick note? In literature we read that patients are very aware of abuses of the system and they feel the need to prove they are genuinely ill(2).

Most patients consider their doctor best-placed to assess their disease status. Just as many think they themselves *and* their GP are best-placed. It is surprising that many patients find that their GP can better judge how sick they are than themselves. We believe that this emphasizes that GP's have a large responsibility in sickness certification and that they should use this "power" cautiously.

## E. Conclusion

This study tries to map the patient's perspective on sickness certification in general practice in Belgium.

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# 4. Abstract

*Background*: Having a paid job on the labour market is seen as the main path towards social inclusion. There is a strong evidence base showing that work is generally good for physical and mental health and well-being. Nevertheless, in Western countries, the amount of time spent on sick leave and the number of long-term claims for disability benefits have increased dramatically over the last decades. The financial burden placed on employers, insurance companies and governments is the main reason that the sickness and disability schemes are viewed as untenable. GP's are the first healthcare professionals consulted by patients who are absent from work through illness. Primary care physicians regard the task of sick listing as one of the most cumbersome in their practice, partly due to a lack of knowledge and training in occupational medicine. The aim of this study is to find criteria to determine sick leave and to find advice on how GP's can enhance the return to work process. Also the Belgian patient's perspective on sickness certification was explored.

*Methods*: Electronic databases were searched from five years before the first search date (November 2011) till the first of July 2012. Inclusion criteria were articles written in English or Dutch in a primary care setting. In the second phase of this study, a written questionnaire, consisting of 22 questions, was composed and handed out to patients between 18 and 65 years old in six general practices in Belgium. Data were analysed by Microsoft Excel.

*Results*: The search yielded 340 papers of which 32 papers were withheld. The medical disease or disablement is by law the most important criteria to determine sick leave. In practice however sickness certification turns out to be a result of a complex assessment process in which doctors also take the patients' experiences, competences and social circumstances into consideration. There are several factors that influence the decision making process: the GP-patient relationship, the GP-colleague relationship, patient and GP characteristics, the assessment of reduced work capacity by patient and GP, shortage of time and a lack of continuity of care. In the UK, the fit note is an attempt to reduce the amount of sick notes. GP's should advise patients on the beneficial effects of work and should help them outline a return to work plan.

367 patient questionnaires were returned. Most patients are required to have a sickness certificate if they are off sick for one day and most of them do not have the possibility to do altered work. When patients consult for a sickness certificate they seldom come only for the sick note but also want reassurance and/or advice. In more than half of the consultations the GP asks about the patient's working conditions or already knows about them. A majority of patients has no anxiety to discuss sickness certification with their GP and do not consider these discussions as a threat to the GP-patient relationship. The patient's views on their influence on the duration of sick leave is divergent, with more than one third of the patients finding they seldom or never have influence. Patients find it a good idea to abolish the sickness certificate for one day but still about 30% of patients do not. Patients claim they don't think that the sick note highers the threshold to stay off work. The patient finds the GP is best-placed to assess their disease status.

*Conclusions*: There is low awareness and use of guidelines concerning sickness certification among GPs. Determining sick leave is a complex evaluation process in which doctors take different types of information into consideration. There is evidence that GP's play an important role in enhancing return to work. Future guidelines should pay more attention to aspects of work and health. This study also tried to map the patient's perspective of sickness certification in general practice.

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I would like to thank all the patients who filled out a questionnaire.
And finally a word of thanks to my family and partner who have truly supported me every step of the way.

# 6. Appendices

## Appendix 1: Description of included studies

| Article | Publication Year | Study Type | Study Population | Aim of the study |
|---|---|---|---|---|
| Van Balen J, Kremer A, Buijs P, Hulshof C, goudswaard L. NHG-standaarden doorgelicht op arbeid. | 2010 | Systematic Review | / | Work-related outcomes and return to work interventions in NHG guidelines. |
| Hashtroudi A, Paterson H. Occupational health advice in NICE guidelines. | 2009 | Systematic Review | / | Work-related outcomes and return to work interventions in NICE guidelines. |
| Managing long-tem sickness absence and incapacity for work. London: National Institute for Health and Clinical Excellence. | 2009 | Public Health Guidance | / | How to manage long-term sickness absence and incapacity. |
| Roope R, Parker G, Turner S. General practitioners' use of sickness certificates. | 2009 | Quantita-tive | Questionnaire for 113 GPs, 77 replied | To assess GPs use of DWP guidelines. |
| Hiscock J, Ritchie J. The role of GP's in sickness certification. | 2001 | Qualitative (Research Report) | 33 GP interviews and 5 discussion groups | Role of GPs in sickness certification. |
| Norrmén G, Svärdsudd K, Andersson DKG. How primary health care physicians make sick listing decisions: The impact of medical factors and functioning | 2008 | Qualitative | GP and patient questionnaires for 474 consultations | The influence of medical factors and functioning on sick listing probability. |
| Dunstan DA. Are sickness certificates doing our patients harm? | 2009 | Qualitative | / | To stress the positive relationship between work and health. |
| Meershoek A, Krumeich A, Vos R. Judging without criteria? Sickness certification in Dutch disability schemes. | 2007 | Qualitative | 20 physicians employed full time in sickness certification | How GPs make sick-listing decisions. |
| Coggan D, Palmer KT. Assessing fitness for work and writing a "fit note". | 2010 | Practice Pointer | / | How to assess fitness for work and how to write a fit note |
| Mowlam A, Lewis J. Exploring how general practitioners | 2005 | Qualitative | / | GPs' approaches to managing sickness absence and assisting patients to return to work. |

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| work with patients on sick leave. | | | | |
| Wynne-Jones G, Mallen CD, Main CJ, Dunn KM. What do GPs feel about sickness certification? | 2010 | Qualitative: A systematic search and narrative review | Studies conducted in primary care with clinically active GPs | GPs' attitudes towards sickness certification.<br>(Conflict, role responsibility, barriers to good practice) |
| Money A, Hussey L, Thorley K, Turner S, Raymond A. Work-related sickness absence negotiations: GPs' qualitative perspectives. | 2010 | Qualitative | Semi-structured telephone interviews with 31 GPs from the UK who reported a case with associates sickness absence in | Negotiation between GPs an patients in sickness absence negotiations an how occupational health trainig may affect this process. |
| O'Brien K, Cadbury N, Rollinck S, Wood F. Sickness certification in the general practice consultation: the patients' perspective, a qualitative study. | 2008 | Qualitative | 19 patient interviews in 12 general practices in South Wales | Patients' views of sickness certification within general practice consultations and how these could be improved. |
| Foley M, Thorley K, Denny M. 'The sick note': A qualatative study of sickness certification in general practice in Ireland. | 2012 | Qualitative | 14 GP interviews in 11 primary health care practices in Ireland | GPs' views on sickness certification, the strategies to issue sickness certificates, and scope for improvement in the current system. |
| Medical Disability Guidelines | / | Guidelines | / | Guidelines on disability duration and thus return to work for many diseases and injuries. |
| Black C. Working for a healthier tomorrow. | 2008 | Review | Britain's working age population | To identify the factors that stand in the way of good health and to elicit interventions, including changes in attitudes, behaviors and practices – as well as services – that can help overcome them. |
| Black C, Frost D. Health at work - an independent review of sickness absence. | 2011 | Indepen-dent review | Britain's working age population | To minimize the loss of work resulting from ill health and to find ways of reducing the burdens and costs. |
| Thornhill S, Williams N. Completion of the Statement of Fitness for Work: concise guidance. | 2012 | Guideline | / | How and when to issue a fit note. |
| Fylan B, Fylan F, Caveney L. An evaluation of the Statement of Fitness for Work: qualitative research with | 2011 | Qualitative (Research Report) | 45 in-depth semi-structured interviews with GPs from the UK | To explore the extent to which the fit note meets its policy objectives to improve assessments of sickness and how this is achieved in practice. What are GPs' experiences of using the |

| | | | | |
|---|---|---|---|---|
| General Practitioners. | | | | fit note?; what role do GPs feel they play in giving return-to-work advice; and how has the fit note influenced their role perceptions? |
| Lalani M, Meadows P, Metcalf H, Rolfe H. Evaluation of the Statement of Fitness for Work: qualitative research with employers and employees. | 2012 | Qualitative (Research Report) | Interviews of 98 employers and 87 employees of 54 organizations | To explore the experiences and outcomes of the fit note from the multiple perspectives of employers and employees and to understand how these differ across businesses and organizations. |
| Michie S, Williams S. Reducing work related psychological ill health and sickness absence: a systematic literature review. | 2003 | Systematic Review | | To detect the work factors associated with psychological ill health and sickness absence. |
| Palmer KT, Harris EC, Linaker C, Barker M, Lawrence W, Cooper C, et al. Effectiveness of community- and workplace-based interventions to manage musculoskeletal-related sickness absence and job loss: a systematic review. | 2012 | Systematic Review | / | To assess the effectiveness of interventions to reduce sickness absence and job loss in workers with musculoskeletal disorders. |
| Joyce K, Pabayo R, Critchley JA, Bambra C. Flexible working conditions and their effects on employee health and wellbeing. | 2010 | Interven-tion Review | / | To evaluate the effects of flexible working interventions on employee health and wellbeing. |
| Duijts SFA, Kant I, Swaen GMH, Van den Brandt PA, Zeegers MPA. A meta-analysis of observational studies identifies predictors of sickness absence. | 2007 | Meta-analysis | / | To identify predictors of sickness absence. |
| Cornelius LR, Van der Klink JJL, Groothoff JW, Brouwer S. Prognostic factors of long term disability due to mental disorders: a systematic review. | 2011 | Systematic Review | People on sick leave or receiving disability benefit at baseline | To investigate current scientific evidence about the prognostic factors for long term disability and return-to-work of persons sick listed due to mental health problems and factors for recovery of mental health symptoms. |

| | | | | |
|---|---|---|---|---|
| Detaille SI, Heerkens YF, Engels JA, Van der Gulden JWJ, Van Dijk FJH. Common prognostic factors of work disability among employees with a chronic somatic disease: a systematic review of cohort studies. | 2009 | Systematic review of cohort studies | Employees between 18-65 years with rheumatoid arthritis, astma, COPD, diabetes mellitus, and ischemic heart disease. | Common prognostic factors for work disability among employees with a not work-related chronic somatic disease. |
| Blank L, Peters J, Pickvance S, Wilford J, Macdonald E. A systematic review of the factors which predict return to work for people suffering episodes of poor mental health. | 2008 | Systematic review | / | Describes the factors which predict or restrict return to work fo people suffering of poor mental health. |
| Waddell G, Burton A. Advising patients about work. | 2008 | Guideline | / | How to advise patients about work. |

## Appendix 2: Factors determining fitness for work and questions that may be helpful in identifying the need for job modifications

**Box 1**

**Factors determining fitness for work**

- Nature and severity of health problem(s)
- Patient's attitudes and expectations
- Physical and mental demands of job
- Potential for work to exacerbate illness
- Safety considerations

**Box 2**

**Questions that may be helpful in identifying the need and scope for job modifications**

- What is your job, and what tasks does it involve?
- Are there aspects of your job that you would find difficult or impossible because of your health problem(s)?
- If so, are there simple ways in which your job could be changed to overcome these difficulties?
- Is there another job that you would find easier, to which your employer might move you while you are recovering?

# Appendix 3: Examples of modifications that may help a patient to return to work and examples of advice for an employer about a patient's function and possible job modifications

**Box 3**

**Examples of modifications that may help a patient to return to work**

**Phased return to work**

The patient could restart with reduced working hours and build up gradually to normal levels. Working fewer hours each day is usually preferable to fewer days each week

**Altered hours**

Consider the time of work as well as the number of hours a day—for example, a patient recovering from depression may find early starts especially difficult

**Amended duties**

Changes in the organisation of work might help: an anxious patient with reduced confidence may benefit from working in a team rather than alone; a secretary with rheumatoid arthritis who found typing difficult could be allocated alternative administrative duties if colleagues were available to share in the work

Changes in job content might help: a patient with back pain may need to avoid prolonged sitting to reduce discomfort; a patient with anxiety or depression may need to avoid tight deadlines; a patient with newly diagnosed insulin dependent diabetes may need to avoid foreign travel temporarily

**Workplace adaptation**

Changes to seating or other aspects of a work station may be necessary to improve comfort in a patient with back pain

A patient with an arthritic left ankle may need to switch to a car with automatic gears

**Box 4**

**Examples of advice for an employer about a patient's function and possible job modifications**

"He should avoid lifting weights greater than 10 kg. Might it be possible for him to transfer temporarily to work in customer service?"

"She should avoid prolonged sitting without breaks. Review of her work station might be useful. She will need time off twice a week to attend physiotherapy"

"She cannot currently drive a car. So that she can use public transport it would help if she could start and finish work a little later than normal"

"He should avoid kneeling and squatting"

"She could manage work that does not involve handling customer complaints"

## Appendix 4: Patient questionnaire

| | | |
|---|---|---|
| | **PATIENT INFORMATION** | |
| 1. | How old are you? | ..... |
| 2. | What is your sex? | ☐ female<br>☐ male |
| 3. | What is your education? | ☐ graduate school/university<br>☐ upper secondary school<br>☐ secondary school<br>☐ primary school<br>☐ no education |
| 4. | I live: | ☐ with wife/husband/partner and (number).....child(ren)<br>☐ with wife/husband/partner<br>☐ with parent(s)<br>☐ alone<br>☐ with (number) .....child(ren) |
| 5. | What is your employment status at this moment? | ☐ employee<br>☐ worker<br>☐ functionary/official/civil servant<br>☐ self-employed<br>☐ student<br>☐ housewife<br>☐ unemployed<br>☐ other, specify.... |
| | **WORK SITUATION** | |
| | | Yes ☐ No ☐ I don't know ☐ Not applicable ☐ |
| 6. | There is a high amount of sickness absence at my work | ☐ ☐ ☐ ☐ |
| 7. | If I am not fit for my normal job I have the possibility to do modified work (altered hours, amended duties, phased return to work, workplace adaptations) | ☐ ☐ ☐ ☐ |
| 8. | My employer requires a sickness certificate if I am off work sick for 1 day | ☐ Yes<br>☐ No, I am allowed to be sick for (number)... day(s) without sickness certificate<br>☐ I don't know<br>☐ Not applicable |
| | **QUESTIONS ABOUT YOUR HEALTH STATUS** | |
| 9. | What was your total time on sick leave the year before this consultation? | ☐ none<br>☐ one week or less<br>☐ more than one week but less than four weeks<br>☐ more than four weeks but less than 3 months<br>☐ more than 3 months<br>☐ not applicable |
| | | |

| | | |
|---|---|---|
| 10. | How do you assess your general health status? | ☐ I am mostly healthy and feel well<br>☐ I have one or more diseases, but I feel well most of the time<br>☐ I have no known diseases, but I feel fairly unwell<br>☐ I have one or more diseases and I seldom or never feel well |
| | **QUESTIONS ABOUT YOUR PRESENT CONSULTATION** | |
| 11. | The sickness certificate was my main reason for consultation today | ☐ yes, if I was not in need of a sick note I would not have come<br>☐ no, I would like a sick note but I was also seeking reassurance/advice/...<br>☐ no, I don't want a sick note<br>☐ no, I don't need a sick note |
| 12. | Did the doctor ask about your working conditions (how many hours you work, how your complaints influence your work capacity, what you do at your job,...)? | ☐ yes<br>☐ no<br>☐ the doctor already knew<br>☐ not applicable |
| 13. | Did the doctor, during the consultation, take other factors into account that you think are important to how you feel (family problems, financial problems, matters concerning your job situation like heavy workload or problems with workmates/manager,...)? | ☐ yes<br>☐ no<br>☐ the doctor already knew<br>☐ not applicable |
| 14. | What do you think was important for the doctor's decision to sick list you or not to sick list you? (tick one box on each row)<br>-results from clinical examination and/or other tests<br>-my medical history<br>-my ability to cope with my work | Very great Import-ance / great import-ance / some import-ance / no import-ance / do not know / *N/A<br>☐ ☐ ☐ ☐ ☐ ☐<br>☐ ☐ ☐ ☐ ☐ ☐<br>☐ ☐ ☐ ☐ ☐ ☐ |
| 15. | What measures did the doctor suggest you to take in order to recover? (more than one cross permitted) | ☐ I received a prescription or was recommended an over the counter drug<br>☐ I got advice on what to eat or drink<br>☐ I got advice on exercise<br>☐ I got advice on smoking<br>☐ I got advice on what to do or avoid doing<br>☐ I got referred for further examination, specify...<br>☐ none<br>☐ not applicable |

| | YOUR OPINION | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Always/mostly/some-/sel-/never/ N/A* | | | | | |
| | | | | times | dom | | |
| 16. | I feel higher levels of anxiety prior to a consultation in which I need to ask for a sick note | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. | I feel that discussing sickness certification with my GP is a threat to our relationship | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. | I can influence the duration of sick leave that is prescribed | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | Yes | | No | | No opinion | |
| 19. | I think it is a good idea to abolish the sickness certificate for 1 day off work | ☐ | | ☐ | | ☐ | |
| 20. | If I wouldn't need a sickness certificate I would stay off work more easily | ☐ | | ☐ | | ☐ | |
| 21. | It is a good thing that social insurance officers make home visits to ensure that there is no cheating with sickness certification | ☐ | | ☐ | | ☐ | |
| 22. | Who is best placed to assess your disease status? (more than one cross permitted) | ☐ me<br>☐ my doctor<br>☐ my employer | | | | | |

*** not applicable**

## Appendix 5: Codex

| | | |
|---|---|---|
| | **PATINFO** | |
| 1. | Age | 1= 18-25 years<br>2=26-35 years<br>3= 36-45 years<br>4= 46-55 years<br>5= 56-65 years |
| 2. | Sex | 1= female<br>2=male |
| 3. | School | 1= graduate school/university<br>2=upper secondary school<br>3=secondary school<br>4=primary school<br>5=no education |
| 4. | Family<br><br><br><br><br><br>kids | 1=with wife/husband/partner and (number).....children<br>2=with wife/husband/partner<br>3= with parent(s)<br>4=alone<br>5=with .....children<br><br>1=1 child<br>2= 2 children<br>3= 3 children<br>4= 4 children<br>5=5 children<br>*0= no children OR no answer |
| 5. | Employst | 1=employee<br>2=worker<br>3=official<br>4=self-employed<br>5=student<br>6=housewife<br>7=unemployed<br>8=other,specify.... |
| | **WORKSITU** | |
| | | Yes No I don't know Not applicable |
| 6. | AmountSa | 1 2 3 4 |
| 7. | Modified | 1 2 3 4 |
| 8. | Oneday<br><br><br><br><br><br>dwc | 1=yes<br>2= No, I am allowed to be sick for (number)... days without sickness certificate<br>3=I don't know<br>4=not applicable<br><br>1= 1 day<br>2= 2 days<br>3= 3 days<br>4= 4 days |

| | | |
|---|---|---|
| | | 5= 5 days<br>6= more than 5 days |
| | **HEALTHST** | |
| 9. | Sickleav | 1=none<br>2=one week or less<br>3=more than one week but less than four weeks<br>4=more than four weeks but less than 3 months<br>5=more than 3 months<br>6=not applicable |
| 10. | Ghs | 1=I am mostly healthy and feel well<br>2=I have one or more diseases, but I feel well most of the time<br>3=I have no known diseases, but I feel fairly unwell<br>4=I have one or more diseases and I seldom or never feel well |
| | **PRESCONS** | |
| 11. | Reason | 1=yes, if i was not in need of a sick note I would not have come<br>2=no, I would like a sick note but I was also seeking reassurance/advice/...<br>3=no, I don't want a sick note<br>4=no, I don't need a sick note |
| 12. | Conditio | 1=yes<br>2=no<br>3=the doctor already knew<br>4=not applicable |
| 13. | External | 1=yes<br>2=no<br>3=the doctor already knew<br>4=not applicable |
| 14. | Decision | Very great some no do N.A.<br>Great import- import- import- not<br>Import- ance ance ance know<br>ance |
| | - Ex | 1 2 3 4 5 6 |
| | - Hi | 1 2 3 4 5 6 |
| | - Co | 1 2 3 4 5 6 |
| 15. | Recovery | 1=I received a prescription or was recommended an over the counter drug<br>2=I got advice on what to eat or drink<br>3=I got advice on exercise<br>4=I got advice on smoking<br>5=I got advice on what to do or avoid doing<br>6=I got referred for furthur examination, specify... |

| | | |
|---|---|---|
| | | 7=none<br>8=not applicable |
| | **OPINION** | Always/mostly/some/seldom/never/n.a. |
| 16. | Anxiety | 1 2 3 4 5 6 |
| 17. | Threat | 1 2 3 4 5 6 |
| 18. | Duration | 1 2 3 4 5 6 |
| | | Yes No No opinion |
| 19. | Abolish | 1 2 3 |
| 20. | Threshol | 1 2 3 |
| 21. | Cheating | 1 2 3 |
| 22. | Assess | 1=me<br>2=my doctor<br>3=my employer<br>4= me+my doctor<br>5=me+my doctor+my employer |

**0=no answer**
***0=no answer or no children**

## Appendix 6: Table of Results

| Code / Question | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | excl |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 27 | 32 | 57 | 83 | 97 | 71 | | | | |
| 2 | 3 | 228 | 136 | | | | | | | |
| 3 | 5 | 222 | 95 | 37 | 4 | 4 | | | | |
| 4 | 2<br>*177 | 185<br>63 | 91<br>91 | 27<br>33 | 42<br>1 | 19<br>2 | | | | 1 |
| 5 | 0 | 171 | 34 | 38 | 30 | 17 | 20 | 16 | 33 | 8 |
| 6 | 23 | 70 | 160 | 62 | 50 | | | | | 2 |
| 7 | 26 | 96 | 151 | 31 | 60 | | | | | 2 |
| 8 | 33<br>294 | 161<br>35 | 90<br>18 | 14<br>12 | 68<br>2 | 2 | 4 | | | 1 |
| 9 | 8 | 110 | 124 | 57 | 14 | 15 | 39 | | | |
| 10 | 10 | 236 | 78 | 27 | 16 | | | | | |
| 11 | 9 | 32 | 105 | 43 | 172 | | | | | 6 |
| 12 | 6 | 91 | 79 | 93 | 94 | | | | | 4 |
| 13 | 9 | 105 | 97 | 67 | 85 | | | | | 4 |
| 14 | 45<br>78<br>68 | 54<br>29<br>45 | 73<br>44<br>55 | 22<br>32<br>36 | 23<br>40<br>22 | 8<br>14<br>9 | 142<br>130<br>132 | | | |
| 15 | 13 | 272 | | | | | | 12 | 70 | |
| 16 | 16 | 15 | 11 | 21 | 54 | 170 | 78 | | | 2 |
| 17 | 15 | 3 | 4 | 10 | 27 | 225 | 82 | | | 1 |
| 18 | 19 | 21 | 35 | 58 | 45 | 89 | 98 | | | 2 |
| 19 | 17 | 158 | 107 | 85 | | | | | | |
| 20 | 18 | 30 | 266 | 51 | | | | | | 2 |
| 21 | 18 | 251 | 40 | 57 | | | | | | 1 |
| 22 | 12 | 41 | 157 | 0 | 154 | 3 | | | | |

0=no answer
*=no answer OR no children
excl= excluded because multiple answers