General practitioners’ use of sickness certificates

Richard Roope¹, Gordon Parker² and Susan Turner³

Background
At present, sickness certification is largely undertaken by general practitioners (GPs). Guidance from the Department of Work and Pensions (DWP) is available to help with this task; however, there has been little formal evaluation of the DWP’s guidance in relation to day-to-day general practice.

Aims
To assess GPs’ training, knowledge and application of the DWP’s sickness certification guidelines.

Methods
A structured questionnaire was sent to GPs within a (former) primary care trust (PCT). It probed demographics, training and knowledge of sickness certification guidelines. Case histories and structured questions were used to assess current practice.

Results
In this group of 113 GPs, there was a low awareness and use of the DWP’s guidelines and Website relating to sickness certification. The majority of the GPs (63%) had received no training in sickness certification, and the mean length of time for those who had received training was 4.1 h. Most GPs also felt that patients and GPs have equal influence on the duration of sickness certification.

Conclusions
This evidence of variable practice indicates that GPs should have more guidance and education in sickness certification. Closer sickness certification monitoring through existing GP computer systems may facilitate an improvement in practice that benefits patients and employers. The DWP, medical educators and PCTs may all have an additional role in further improving sickness certification practice.

Key words
Cost of sickness; general practice; occupational medicine; sickness absence duration; sickness certification.

Introduction
The annual cost to the UK economy of sickness absence and worklessness is estimated at >£100 billion every year [1] per year. Although some sickness certification is undertaken in secondary care, and some is self-certified (by patients), general practitioners (GPs) remain largely responsible for this task. This estimate is 10 times the annual primary care prescribing costs of £8.2 billion in 2006 [2]. This parallel has been drawn before by Norrme¯n et al. [3] who quoted the following from Tibblin ‘sickness certification may be regarded as a drug with effects and side effects, it should be handled in the same way as a medical prescription’.

In 1996, it was suggested that the inclusion of occupational health topics in vocational training for GPs was limited [4]. This was attributed to course overloading and also to a lack of contact between occupational physicians (OPs) and GPs. There is little information as to how much specific training GPs receive in sickness certification and how effective they are in this role; however, Hardy [5] felt that GPs wrote sick certificates unthinkingly, inconsistently and irresponsibly.

In comparison, inconsistencies are known to exist between doctors in their patterns of issuing sickness certificates [6–8], with substantial disagreement regarding their recommendations on the duration of sick leave [7]. There may also be varying levels of professionalism in carrying out the role of sickness certification [7], as GPs may fail to translate their knowledge about the importance of the task when issuing sickness certification. Such failures contradict guidance from both the General Medical Council and the Faculty of Occupational Medicine in the UK [9,10].

Hussey et al. [11] observed that, for most GPs, their responsibility to the patient outweighed responsibilities to the Department of Work and Pensions (DWP) or to the employer. However, this behaviour is based on the assumption that an employee is best served by receiving a sick certificate and that the DWP/employer is not. This may also reflect a GP’s view that signing a sickness certificate is the best course of action, disregarding the fact that...
worklessness is detrimental and that active rehabilitation may play a significant role in helping patients/employees to improved health [1,12].

The DWP has issued guidelines [13] to assist GPs in the process of sickness certification, but it is not known to what extent these are used. This study aims to assess GPs’ training, knowledge and application of the DWP’s sickness certification guidelines.

**Methods**

An introductory letter and structured questionnaire were posted to all 113 GPs who were listed in the Fareham and Gosport Primary Care Trust (PCT) on 1 May 2006 asking the following:

- Gender of the GP
- Year of qualification as a GP
- Medical qualifications [e.g. Membership of The Royal College of General Practitioners (MRCGP)]
- Number of sessions per week worked as a GP (and/or OP)
- Awareness, knowledge and use of the DWP’s guidelines on sickness certification and of the DWP’s Website

Study participants were also asked to indicate how long they would expect to sign a patient off work on health grounds using tick box options for the following time periods (in weeks); 1–2, 2–3, 4–6, 7–10, 11–13 and >13. Case vignettes provided in the DWP’s guidance [12] were used as examples, namely: uncomplicated laparoscopic inguinal hernia repair, uncomplicated abdominal hysterectomy and myocardial infarction (MI) without complications.

The GPs were also asked about length of training that they had received in occupational health and in sickness certification and finally for their opinion on who had the most influence on the duration of sickness certification (using a five-point scale = GP only, mainly GP, even mix of GP/patient, mainly patient, patient only).

A second questionnaire was sent to non-responders after 3 weeks.

Data were analysed using Microsoft Excel software. Where responses were given in the form of a range of days or weeks, mean and standard deviation calculations were based on the mid-range value for each of the possible answer ranges. Statistical analysis used the χ² test, Fisher’s exact test and Pearson’s correlation coefficient.

Ethical approval was granted by The Centre for Occupational Health’s Ethics Committee at the University of Manchester, The Portsmouth NHS R&D Consortium LREC (06/Q1701/31) and The Fareham and Gosport Primary Care Trust (F&GPCT/2006/02ST).

**Results**

Of the 113 GPs who were sent the questionnaire, 77 (68%) replied. The majority of responders (44/77; 57%) were male and 49 (64%) held the MRCGP. There was a wide range of year of qualification as a GP from ‘before 1975’ (8%) to ‘2000–06’ (5%), but the majority (53%) qualified between 1980 and 1994. Analysis of study data and information in the public domain showed no significant difference between the responders and non-responders for gender or General Medical Council registration year.

Only 2/77 (3%) undertook one or more sessions of occupational medicine practice per week, and both of these GPs held the Diploma in Occupational Medicine (DOccMed) of the Faculty of Occupational Medicine (UK). Of note, there were two other holders of the DOccMed who were not undertaking any clinical occupational medicine sessions when this study was conducted.

<table>
<thead>
<tr>
<th>GP Type</th>
<th>Number of GPs</th>
<th>Aware n (%)</th>
<th>Statistics</th>
<th>Use n (%)</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>DWP’s guidelines</td>
<td>Total</td>
<td>77</td>
<td>28 (36)</td>
<td>χ², NS</td>
<td>15 (20)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>44</td>
<td>13 (30)</td>
<td></td>
<td>7 (16)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>33</td>
<td>15 (45)</td>
<td></td>
<td>8 (24)</td>
</tr>
<tr>
<td></td>
<td>MRCGP</td>
<td>49</td>
<td>21 (43)</td>
<td>Fisher’s exact test: NS</td>
<td>14 (29)</td>
</tr>
<tr>
<td></td>
<td>No MRCGP</td>
<td>28</td>
<td>7 (25)</td>
<td>Fisher’s exact test: NS</td>
<td>1 (4)</td>
</tr>
<tr>
<td>DWP’s Website</td>
<td>Total</td>
<td>77</td>
<td>21 (27)</td>
<td>χ², NS</td>
<td>7 (9)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>44</td>
<td>11 (25)</td>
<td></td>
<td>1 (2)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>33</td>
<td>10 (30)</td>
<td></td>
<td>6 (18)</td>
</tr>
<tr>
<td></td>
<td>MRCGP</td>
<td>49</td>
<td>16 (33)</td>
<td>Fisher’s exact test: NS</td>
<td>5 (10)</td>
</tr>
<tr>
<td></td>
<td>No MRCGP</td>
<td>28</td>
<td>5 (18)</td>
<td>Fisher’s exact test: NS</td>
<td>2 (7)</td>
</tr>
</tbody>
</table>

*One responder gave no answer to the ‘DWP Website use’ question.

NS, not significant (P > 0.05).
Other findings of note were that only a third (36%) of responders were aware of the DWP's guidelines, and even fewer (20%) used them; the corresponding findings about the DWP's Website were even lower, awareness and use being 27 and 9%, respectively (Table 1). Although some statistically significant differences were found for awareness and use of the DWP's guidelines/Website (when analysed by possession of MRCGP and GP gender), group sizes used for these analyses were very small.

The results for each vignette were analysed by GP gender, awareness of DWP guidelines/Website and use of the DWP guidelines/Website. The term 'correct response' equates to DWP guidelines and 'incorrect response' indicates an alternative response (to DWP guidelines) from the GPs.

The questionnaire asked how long the GP would certify sickness absence for a 28-year-old male full-time computer technician, who had undergone an uncomplicated laparoscopic inguinal hernia repair, with DWP guidelines [12] recommending '1–2 weeks'. Proportionately, female GPs and those who were aware of (and used) DWP guidelines/Website gave more correct responses, but none of these findings was statistically significant (Table 2). Of note, the minimum and maximum absences recommended by the GPs for each of the subdivisions shown in Table 2 was 1–2 weeks to ‘4–6 weeks’. Analysis of duration of sickness certification by year of qualification as a GP was not found to be statistically significant.

The next vignette looked at a 42-year-old female employed as a nurse in a local accident and emergency department who had undergone an uncomplicated abdominal hysterectomy. Only a quarter (23%) of GPs used the DWP's recommended period of absence (7 weeks) (Table 3); 35% suggested a longer period, while 42% recommended a shorter one. The range of certified absence is also given, the shortest period being 2–3 weeks and the longest exceeding 13 weeks. Although not shown here, there was no statistically significant association between year of qualification as a GP and duration of the sickness certificate.

The third vignette was a 49-year-old male garage mechanic who had experienced a MI, for which the DWP guidelines recommend an absence period of 4–6 weeks. The overall average period of sickness absence recommended by GPs (6.3 weeks) was just outside the DWP's recommended range. More than half the responders suggested the correct period of absence, a third suggested a longer period than is recommended and 13% suggested

<table>
<thead>
<tr>
<th>GPs</th>
<th>Number of GPs</th>
<th>Correct responses n (%)</th>
<th>Incorrect responses n (%)</th>
<th>Statistics</th>
<th>Range of absence advised (weeks)</th>
<th>Mean (days)</th>
<th>SD (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>77</td>
<td>43 (56)</td>
<td>34 (44)</td>
<td></td>
<td>1–2 to 4–6</td>
<td>13.7</td>
<td>8.2</td>
</tr>
<tr>
<td>Male</td>
<td>44</td>
<td>22 (50)</td>
<td>22 (50)</td>
<td>$\chi^2$, NS</td>
<td>1–2 to 4–6</td>
<td>14.1</td>
<td>7.5</td>
</tr>
<tr>
<td>Female</td>
<td>33</td>
<td>21 (64)</td>
<td>12 (36)</td>
<td></td>
<td>1–2 to 4–6</td>
<td>13.2</td>
<td>9.2</td>
</tr>
<tr>
<td>Guideline/web aware</td>
<td>38</td>
<td>24 (63)</td>
<td>14 (37)</td>
<td>$\chi^2$, NS</td>
<td>1–2 to 4–6</td>
<td>12.4</td>
<td>7.5</td>
</tr>
<tr>
<td>Guideline/web unaware</td>
<td>39</td>
<td>19 (49)</td>
<td>20 (51)</td>
<td></td>
<td>1–2 to 4–6</td>
<td>15.0</td>
<td>8.8</td>
</tr>
<tr>
<td>Guideline/web used</td>
<td>20a</td>
<td>15 (75)</td>
<td>5 (25)</td>
<td>Fisher's exact test: NS</td>
<td>1–2 to 4–6</td>
<td>11.1</td>
<td>7.9</td>
</tr>
<tr>
<td>Guideline/web never used</td>
<td>56a</td>
<td>27 (48)</td>
<td>29 (52)</td>
<td></td>
<td>1–2 to 4–6</td>
<td>14.8</td>
<td>8.2</td>
</tr>
</tbody>
</table>

*aOne responder gave no answer to the ‘DWP guideline/Website use’ questions.
NS, not significant (P > 0.05).

<table>
<thead>
<tr>
<th>GPs</th>
<th>Number of GPs</th>
<th>Correct responses n (%)</th>
<th>Incorrect responses n (%)</th>
<th>Statistics</th>
<th>Range of absence advised (weeks)</th>
<th>Mean (weeks)</th>
<th>SD (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>77</td>
<td>18 (23)</td>
<td>59 (77)</td>
<td>Fisher's exact test: NS</td>
<td>2–3 to &gt;13</td>
<td>8.2</td>
<td>3.3</td>
</tr>
<tr>
<td>Male</td>
<td>44</td>
<td>12 (27)</td>
<td>32 (73)</td>
<td></td>
<td>2–3 to &gt;13</td>
<td>8.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Female</td>
<td>33</td>
<td>6 (18)</td>
<td>27 (82)</td>
<td>Fisher's exact test: NS</td>
<td>2–3 to 11–13</td>
<td>7.9</td>
<td>3.4</td>
</tr>
<tr>
<td>Guideline/web aware</td>
<td>38</td>
<td>11 (29)</td>
<td>27 (71)</td>
<td>Fisher's exact test: NS</td>
<td>2–3 to 11–13</td>
<td>8.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Guideline/web unaware</td>
<td>39</td>
<td>7 (18)</td>
<td>32 (82)</td>
<td>Fisher's exact test: NS</td>
<td>2–3 to &gt;13</td>
<td>8.3</td>
<td>3.5</td>
</tr>
<tr>
<td>Guideline/web used</td>
<td>20a</td>
<td>5 (25)</td>
<td>15 (75)</td>
<td>Fisher's exact test: NS</td>
<td>4–6 to 11–13</td>
<td>7.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Guideline/web never used</td>
<td>56a</td>
<td>13 (23)</td>
<td>43 (77)</td>
<td></td>
<td>2–3 to &gt;13</td>
<td>8.5</td>
<td>3.4</td>
</tr>
</tbody>
</table>

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NS, not significant (P > 0.05).
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Table 4. Responses to MI vignette

<table>
<thead>
<tr>
<th>GPs</th>
<th>Number of GPs</th>
<th>Correct responses n (%)</th>
<th>Incorrect responses n (%)</th>
<th>Statistics</th>
<th>Range of absence advised (weeks)</th>
<th>Mean (weeks)</th>
<th>SD (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>77</td>
<td>40 (52)</td>
<td>37 (48)</td>
<td>χ² = NS</td>
<td>1–2 to 4–6</td>
<td>6.3</td>
<td>3.2</td>
</tr>
<tr>
<td>Male</td>
<td>44</td>
<td>23 (52)</td>
<td>21 (48)</td>
<td></td>
<td>1–2 to 4–6</td>
<td>6.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Female</td>
<td>33</td>
<td>17 (52)</td>
<td>16 (48)</td>
<td></td>
<td>1–2 to 4–6</td>
<td>6.3</td>
<td>3.1</td>
</tr>
<tr>
<td>Guideline/web aware</td>
<td>38</td>
<td>20 (53)</td>
<td>20 (47)</td>
<td>χ² = NS</td>
<td>1–2 to 4–6</td>
<td>6.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Guideline/web unaware</td>
<td>39</td>
<td>20 (51)</td>
<td>19 (49)</td>
<td></td>
<td>1–2 to 4–6</td>
<td>6.0</td>
<td>3.1</td>
</tr>
<tr>
<td>Guideline/web used</td>
<td>20a</td>
<td>12 (60)</td>
<td>8 (40)</td>
<td>Fisher’s exact test: NS</td>
<td>1–2 to 4–6</td>
<td>5.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Guideline/web never used</td>
<td>56a</td>
<td>28 (50)</td>
<td>28 (50)</td>
<td></td>
<td>1–2 to 4–6</td>
<td>6.6</td>
<td>3.1</td>
</tr>
</tbody>
</table>

*One responder gave no answer to the ‘DWP guideline/Website use’ questions.

Discussion

This study showed low levels of awareness and use of the DWP’s guidelines and Website relating to sickness certification. Advised ranges of sickness absence were greater for an abdominal hysterectomy vignette than for inguinal hernia and MI vignettes, which may reflect changes in medical practice relating to specific diagnoses or study participants’ knowledge and clinical experience. Most GPs felt that patients and GPs have equal influence on the duration of sickness certificate duration.

Clayton and Verow [14] found similar awareness levels for GPs (32%) about the DWP’s guidance as was found here and may in part explain why the range of duration for sickness certification was variable. Most of the GPs (63%) in this study had not received any training in sickness certification, and the mean length of training for those who had was 4.1 h, which (from non-published information) appears to be reasonably representative of this activity.

Clayton and Verow also demonstrated that only 22% of health care practitioners gave advice that concurred with the guidelines for the abdominal hysterectomy vignette (mirroring the 23% in this study). Unfortunately, there were no comparative data within Clayton and Verow’s work for the inguinal hernia and MI vignettes, and although the GPs in the current study showed better agreement with the DWP’s recommendations for sickness certification (inguinal hernia vignette showing 56% ‘agreement’ and MI 52%), neither of these agreement scores is high. This varying practice is not fair either to the patient/employee or to the employer, and as Timpka et al. [15] have stated, certification should be fair and demonstrate quality and precision (which this study fails to find). Additionally, difficulties associated with implementing evidence-based guidance have also been documented, and guidelines (even with educational support) may not necessarily change practice [16].
The study found that older GPs gave sickness certification for a longer duration for the MI vignette than their younger colleagues. This may represent the changes in management of MI over time, the influences of an individual's training and perhaps inertia to change practice despite evidence-based guidelines [13]. Reiso et al. [17] have also suggested a 'grandparent' effect, whereby patients seek out an older doctor believing they will get a more empathetic hearing or possibly that older doctors have lost their resistance to requests for longer sickness certificates. Further studies could therefore investigate current practice in conditions where there has been a change in the pattern of care over time.

A strength of this study was that it reached all GPs in a (former) PCT, and therefore, sampled a wide range of practices in terms of population size and social setting (ranging from inner city practices to affluent middle class areas). Of note, at least one GP replied from every practice, producing a response rate of 68%. Also of note was that the demographics for responding GPs were similar to those of non-responders, which helps to rule out potential biases in the responder subgroup. More specifically, the mean number of years since GP qualification for responders and non-responders was 20.7 and 19.1 years respectively, and the proportions of males were 57% for responders and 62% for non-responders; when tested formally, there was no significant statistical difference for GP qualification date or gender.

This study had limitations because it tested the handling of vignettes rather than real patients in real settings. The use of vignettes is widely accepted for training and educational purposes, however, as this methodology allows identical information to be provided to all study participants. Of course in a ‘real life’ situation, the GP is likely to know the patient, so there is potential scope for a wide range of additional influences and behaviours, with other studies mentioning collusion and perhaps the opportunity for the patient to achieve the duration of sickness certification that (s)he was seeking [11]. Perhaps, most pertinent of all is that this was not a study of certificates that had actually been issued but was a perception of practice. In order to research actual cases, consistent recording of current practice on GP computer systems is needed as is already used for prescribed medication.

It has been suggested that certification of ‘straightforward’ cases is not a problem [11], but this study showed substantial variation in certification assigned to three uncomplicated clinical scenarios. If inconsistencies are to be improved, occupational medicine and general practice educators need to play a significant role helping GP colleagues meet their learning needs, both during their training and as part of annual personal development plans. Beaumont [16] researched the interaction between GPs and OH professionals and concluded that improved communication by mutual education and understanding would be beneficial, which would be relevant in sickness certification.

Furthermore, the study tested GPs’ responses where the only options for certification are ‘you should refrain from work’ or ‘you need not refrain from work’. Proposed changes to UK sickness certification legislation would allow GPs the option ‘you may be fit for some work now’, with a small range of suggested adaptations that the employer should consider (including altered hours, amended duties and workplace adaptations) [18].

The Quality and Outcomes Framework (QOF) has been used to raise standards of management and treatment of several chronic diseases in primary care [19]. QOF could be used to improve standards in sickness certification. If sickness certification is computerized (as proposed in the changes to the UK medical certification legislation), this would allow research of this process and comparisons could be made between practices (as is currently the case for prescribing of medication). It would not be a huge burden to set a new QOF target to record the patient’s occupation, which would have the advantage of encouraging the GP to start thinking about the interactions between work and health.

Although we do not know the true variability of sickness certification, much can be deduced from this study and previous work. There is also room for optimism in that, following on from Dame Carol Black’s review ‘Working for a healthier tomorrow’ [1], a national initiative can reach out to GPs to install a change of mindset to enable effective negotiation and early intervention to facilitate a timely return to the workplace. The financial consequences of sickness absence are a good reason to computerize sickness certification and to facilitate change in the current unsatisfactory environment for sickness certification.

In conclusion, sickness absence certification is poorly administered and as a result hugely variable. Historically very little training in this area is entered into at present and predictably knowledge of evidence-based practice is poor. Changes are essential if this important area of health care is to maximize the health of the workforce.

Key points
- There was a low level of awareness and use by general practitioners of the Department of Work and Pension’s guidelines and Website relating to sickness certification.
- Advised ranges of sickness absence were greater for an abdominal hysterectomy vignette than for inguinal hernia and myocardial infarction vignettes.
- Most general practitioners felt that patients and general practitioners have equal influence on the duration of sickness certificate duration.
Acknowledgements

We thank Melanie Carder from the Occupational and Environmental Health Research Group at the University of Manchester for her help with the statistics; Personnel within the Occupational and Environmental Health Research Group, The University of Manchester, for their support and encouragement and GPs in the former Fareham and Gosport PCT area.

Conflicts of interest

R.R. works as a GP and as an independent occupational health physician.

References