Inside the fitness for work consultation: a qualitative study

D. A. Cohen¹, M. Aylward¹ and S. Rollnick²

Background Evidence now suggests that work is generally good for physical and mental health and well-being. Worklessness for whatever reason can lead to poorer physical and mental health. The role of the general practitioner (GP) in the management of fitness for work is pivotal.

Aims To understand the interaction between GP and patient in the fitness for work consultation. This study forms part of a larger research project to develop a learning programme for GPs around the fitness for work consultation based on behaviour change methodology.

Methods A qualitative study set in South Wales. Structured discussion groups with seven GPs. Two sessions each lasting 3 h were conducted to explore the GP and patient interaction around the fitness for work consultation. Multiple methods were used to enhance engagement. Thematic analysis was used to analyse the data.

Results Four major themes emerged from the meetings: role legitimacy, negotiation, managing the patient and managing the systems. Within these, subthemes emerged around role legitimacy. ‘It’s not my job’, ‘It’s not what I trained for’ and the ‘shifting agenda’. Negotiation was likened to ‘A polite tug of war’ and subthemes around decision making, managing the agenda and dealing with uncertainty emerged.

Conclusions This study starts to unravel the complexity of the fitness for work consultation. It illustrates how GPs struggle with the ‘importance’ of their role and ‘confidence’ in managing the fitness for work consultation. It addresses the skilful negotiation that is required to manage the consultation effectively.

Key words Behaviour change; physician–patient relationship; sickness certification.

Introduction

Many general practitioners (GPs) in the UK are keen to give up sickness certification due to concerns such as patient advocacy, time constraints and lack of knowledge and training in occupational medicine [1,2]. European studies have also concluded that sickness certification is problematic for GPs [3,4]. Alexanderson and Norlund [4] reviewed GP certification practices across Europe and showed that GPs had the greatest difficulty in certification for common health problems. Von Knorring et al. [5] concluded that many of the problems GPs encountered related to inadequate leadership and management of certification issues.

Evidence now suggests that overall the benefits of work outweigh the risk to an individual’s health and are greater than the harmful effects of long-term unemployment and prolonged sickness absence [6]. In addition, research suggests that there is a ‘window of opportunity’ between 1 and 6 months where rehabilitation is likely to be most successful [7,8]. Early intervention seems pivotal to recovery. The Royal College of General Practitioners in the Health and Work Handbook [9] advise that a patient’s capacity for work should form a part of the GP’s clinical management plan. What is not clear is whether the desire of GPs to withdraw from their role with regards the certification process may to some degree reflect the difficulties they encounter in managing consultations about fitness for work, rather than the belief that work and health per se should be beyond the remit of the GP.

This paper describes a qualitative study that investigated the GP consultation about work and health. The work formed the first phase of a larger study that aimed to understand whether an educational programme based on the principles of behaviour change could bring about an attitudinal change in GPs in the management of a consultation around work and health. The aim of this study...
was to clarify the issues that affect the interaction between the GP and the patient from the GP perspective. This data then informed the development of an educational programme that looked at the management of work and health consultations. This study aimed to move away from GPs’ perceptions around the process of sickness certification and focus on the consultation itself. The evaluation of the educational programme will be reported in a further paper.

Methods

The study took place in 2004 and was funded by the UK Government Department for Work and Pensions (DWP). It was time limited and followed the principles of motivational interviewing [10] and action research [11]. Action research has been described as being particularly useful in identifying problems in clinical practice. It can ‘bridge the gap’ between theory and practice by drawing on practitioners’ experience and intuition to generate meaningful and useful outcomes [9]. Inherent in this style of research is that the design of the study must be continually negotiated with the participants.

The study was conducted over a period of 8 months and required the recruitment of a group of GPs whose role was that of ‘key informants’. GPs were recruited opportunistically using personal contact by the researchers with GPs. There were no financial incentives but all costs for the GPs were met. Five 3-h discussion groups were conducted over a period of 6 months. GPs were selected from South Wales and included practices from Cardiff (urban), the Vale of Glamorgan (semi-rural) and Merthyr Tydfil (semi-rural with high deprivation score). The first two meetings aimed to engage participants with the study and asked ‘What goes on inside the consultation around fitness for work?’ Meetings 3 and 4 built on ‘change talk’ that emerged from the discussions and moved to ‘action talk’. Here, the question presented centred on ‘How might the consultation be improved?’ Meeting 5 consolidated participants’ experiences and asked ‘What might an intervention look like?’ This led to the construction of guiding principles and practical tips for the development of an educational programme. The content of each meeting was negotiated with the participants. Findings were fed back to the participants and informed decisions about the structure and content of subsequent meetings. Multiple methods were used to enhance engagement and achieve triangulation [12]. Triangulation strengthens interpretation of the data by synthesizing data collected by different methods.

Simulated patient consultations were carried out both in the discussion groups and also in the participants’ surgeries. These consultations were analysed with the participants to develop a clearer understanding of the interactions. The discussion groups were audio recorded and field notes taken. At the time of the study (2004), ethical approval was sought from the All Wales Ethics Committee but was not required. The audio recordings of all meetings were transcribed and anonymized. Thematic content analysis was employed [13]. The unabridged transcripts were read alongside the field notes for each meeting. Triangulation was achieved by reviewing the transcripts of the simulated patient interactions. Emergent themes were identified and a coding framework constructed by the principal researcher. Data collection continued until data saturation was reached and no new themes emerged. The framework was reviewed with an independent qualitative researcher and analysed by discussion with the facilitator and the principal researcher until the final thematic coding was agreed. A decision was made to separate these data into the principal research questions: (i) What goes on inside the consultation? (ii) How might the consultation be improved? and (iii) What might the intervention look like?

Results

The socio-demographic data of the participating GPs are shown in Table 1.

The first two meetings considered the question: what goes on inside the fitness work consultation. Four major themes emerged: role legitimacy—‘what’s my job?’ negotiation—‘hawk or dove?’ managing the patient—‘what’s best for you?’ and managing the systems—‘making compromises’.

When considering role legitimacy, there was uncertainty as to whether the GP’s role was clearly defined enough. Lack of training was a strong theme. There was consensus that the scarcity of training in occupational health and sickness certification led newly qualified GPs to believe that the subject was not of high importance.

Some participants believed that the work and health consultation needed to be considered within the wider context of changing societal attitude and the political agenda. Participants described the difficulties and frustrations with managing the consultation in the context of shifting welfare reforms and local businesses employment policies. Examples of participant’s views are shown in Box 1.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Hours worked</th>
<th>Trainer</th>
<th>Practice location</th>
<th>Deprivation score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>Full time</td>
<td>Yes</td>
<td>Urban</td>
<td>High</td>
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<tr>
<td>2</td>
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<td>Full time</td>
<td>No</td>
<td>Urban</td>
<td>High</td>
</tr>
<tr>
<td>3</td>
<td>Male</td>
<td>Full time</td>
<td>No</td>
<td>Urban</td>
<td>High</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>Part time</td>
<td>No</td>
<td>Semi-rural</td>
<td>Low</td>
</tr>
<tr>
<td>5</td>
<td>Female</td>
<td>Full time</td>
<td>Yes</td>
<td>Semi-rural</td>
<td>Low</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>Part time</td>
<td>No</td>
<td>Urban</td>
<td>Low to High</td>
</tr>
<tr>
<td>7</td>
<td>Male</td>
<td>Full time</td>
<td>No</td>
<td>Semi-rural</td>
<td>Low</td>
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</tbody>
</table>
Box 1.

‘Definitely, yes I mean I only qualified last year, up until talking about all this it wasn’t really something I made any efforts to address, I just give them the note really more or less whatever they wanted’. ‘In 1980s doctors were being pushed to certificate more because the government wanted to massage the unemployment figures. Now they want doctors to certificate less and move towards more rehabilitation’.

There was consensus that negotiation with patients around sickness certification and their ability to work was difficult. Participants described lack of confidence in negotiating with patients due to the uncertainty of patients’ expectations, managing the agenda and making decisions. Negotiation was likened by one participant to ‘A polite tug of war’. One participant explained that if he had already developed a relationship with the patient, he felt he was able to be more direct (hawkish). If the patient was unknown to the doctor, there was consensus within the group that they might be less aggressive in their approach (dove like). Participants agreed that difficulties arose when the agenda was left unsaid, e.g. patients waiting till the end of a consultation to ask for a sick note. This often left the doctor feeling frustrated and manipulated by the patient. Participants described this like a ‘war of wits’. Some participants felt that their own feelings about work and health might also affect how they managed the consultation.

There was consensus that understanding ‘what was best’ for the patient was of high importance and that GPs had to ask about social and psychological factors to put a request for certification into context. Participants also recognized that some practice processes compromised decision making and that time management affected the quality of GPs’ decision making. Participants described managing their time as ‘often damage limitation during a surgery’. Illustrations of these themes are shown in Box 2.

Meetings 3 and 4 asked the question ‘how might the consultation be improved?’ Participants watched video of ‘common’ and ‘better’ practice of antibiotic prescribing followed by a video of common sickness certification to stimulate reflection on the consultation. Three major themes emerged around principles of good practice: ‘sick note or bust’, ‘defensive negotiation’ and ‘know the field’.

Some participants recognized that their interaction with patients was more adversarial when dealing with certification. However, there was consensus that the consultation should ‘focus on the patient, the problem and good medical practice’ and move away from making assumptions about patients’ expectations. Some participants reflected how their approach to the consultation had changed since the study had started. It was from this discussion that the theme of sick note or bust and ‘take a step back’ emerged. Central to this theme was the neutrality of the practitioner at the start of the consultation. It was not so much about a change in consultation skills but an attitude to the consultation.

There was consensus that feeling defensive in consultations made it difficult to practice good medicine and affected consulting skills. Participants related defensiveness to lack of knowledge and systems but recognized this impacted on how they spoke to the patients. There was a strong feeling that by exploring concerns around work helped shift the balance of the consultation. There was consensus that GPs needed to understand the evidence around work and health to support their clinical decision making. Participants described ‘knowing the field’ as having three main components. First, knowledge of ‘the systems’ such as what support is available for their patients as well as understanding the benefit system. Second, ‘the facts’ about ill-health and unemployment and third, the ‘social and economic issues’, i.e. understanding the personal consequences of being out of work for a patient and family. There was strong consensus that knowing the field gave GPs increased confidence to have a more effective consultation and develop a more meaningful management plan although it might not alter the final outcome (Box 3).

Participants were asked to consider practical tips they would offer a GP registrar in managing a consultation.

Box 2.

‘Because it’s the first time she’s seen me about it, there’s absolutely no way in this world, I can’t give her a sick note. The only way you could do that would be to rubbish who has seen her before. You can’t do that. So again, as far as this consultation is concerned, she’s having a note whatever she says’. ‘We don’t know who’s going to come next or what’s going to be the problem of the person next, so we want to deal with that in the 6 minutes, 10 minutes allocated. So practically, and practical means we are going to go to the fastest, quickest, safest way! And that sometimes wrongly is signing a paper’. ‘In real life I would do that. I would offer a closed statement Med 3 (sickness certificate), because again it’s Friday …. So I would do it for Tuesday and I would be the hawk dressed up as a dove, in that I would be very nice to her, and very approachable, and I would say look if it is not going, it has been going on for a while, come back to see me on Tuesday, I’m here. So that you are saying, if you have any other problems, I am a very nice doctor that you can come and talk to me but if you are coming with a sore throat you are going to have the sore throat treatment and that’s it’.
around work and health. From this discussion, three themes emerged: ‘ask permission and broaden the consultation’, ‘look at the whole picture’ and ‘consider the management plan’.

Discussion centred on how participants had changed their own practice. Participants recognized that experience and a balanced approach to the consultation was important.

They discussed how the ‘whole picture’ involved understanding the wider agenda for the patient such as their social context as well as the medical aspects of the presenting problem. Participants reached consensus that work-related issues should become part of the management plan, but recognized this was not a simple task. They summarized these themes into three practical tips: ‘shift the focus of the consultation’, ‘explore the request for a certificate’ and take a step back (Box 4).

The final session explored the structure and content of the educational programme. Participants felt the key principles and practical tips that they had explored over the previous two sessions should be embedded in the educational programme. Through discussion, the participants expanded these to a list of 17 points that should be included in the programme. This consisted of knowledge-based information, skills training and resources such as a list of recuperation times, case scenarios and information about the legal frameworks around benefits. The final list is shown in Table 2.

The medium for delivering the educational programme was also explored. Participants described their experiences of e-learning and reached consensus that this was a useful method for large group learning. Participants also believed that interactive computer programs helped individualize learning.

An educational programme was developed following the principles of motivational interviewing and focused on changing practitioners’ behaviour. It was informed by the qualitative work and contained the key principles that emerged from the data. The aim of the programme was to guide GPs to reflect on their own practice and offer them alternative strategies and evidence-based information that might inform their future practice. This was achieved by focusing on one case study. The method employed in the programme was to show the case study twice using two different strategies. The GPs were then asked to reflect on the effectiveness of each strategy and rate each consultation.

Discussion

This qualitative study found that in spite of training to place the patient at the centre of the consultation, this was generally not the case when GPs considered the work and health agenda and sickness certification. Participating GPs felt that this was due to the often challenging nature of these types of discussions.

The study identified several factors that explain why GPs find the consultation so challenging. Some factors relate to the level of importance GPs give to the work and health agenda, which in turn relates to the low priority it has been given in training to date. Low importance

### Table 2. Topics to be included in the educational programme

<table>
<thead>
<tr>
<th>Topics</th>
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<tr>
<td>Benefits of health related to work</td>
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<tr>
<td>Communication skills</td>
</tr>
<tr>
<td>Shared understanding</td>
</tr>
<tr>
<td>Continuity of care</td>
</tr>
<tr>
<td>Implications of having or not having a sick note</td>
</tr>
<tr>
<td>What is in it for the patient to have a note and what is in it for the doctor to give a note</td>
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**Box 3.**

‘We presume they come in to get a sick note. They presume that they, to legitimise their consultation, they had better accept a sick note, bit like accepting the antibiotic prescription’.

‘So now fairly routinely now if somebody asks me for a sick note I just sort of say, tell me about your job and what it is that you’re in that prevents you doing it? And nothing more than that. And if at the end of it they say, I need a fortnight off, I say yes but require them to perhaps explain, not a big deal because you’ve only got seven or eight minutes, so it wasn’t going to be, not confrontational, not arguing with them about it, but just ask them to explain what their job was and why their condition prevented them from doing it’.

**Box 4.**

‘One thing is becoming clearer we need to signal intentions. Need to be careful about unpleasantness and how we manage expectations’.

‘I’ve probably been doing a bit like that and also asking patients when they think they are going to go back to work. You know sort of saying, when do you see yourself going back?’

‘I don’t think that with these people we are going to make much difference, it’s the ones that perhaps if we approach things differently they are going to be less off on the sick than others. But the professionally sick ones, I don’t think that you are going to make much difference’.
adds to the uncertainty GPs expressed in understanding their role with respect to the management of work and health issues. Other factors related to GPs' confidence in managing the consultation. Participants recognized that the consultation was complex and the tension between managing a difficult conversation and coping with the ever increasing demands of general practice added to their difficulty. Participants felt that improved knowledge alongside enhanced communication skills such as shared decision making and managing expectations could lead to a more effective consultation about work and health. Participants also explored what an effective educational programme for GPs might look like and gave a clear indication that context-bound learning was of high importance. In summary, this study provided insight into the interaction between doctor and patient that went beyond the participant's attitudes to the process of certification which is an area of work that has not been greatly explored to date.

The study had a number of potential limitations. The sample consisted of seven GPs from the South Wales area which raises the question whether this was a representative sample. Recruiting a stable GP group over a period of 9 months had inherent difficulties. However, the results of the first two meetings showed that the attitudes and beliefs held by the group were comparable to a number of previous studies that explored this area [1,2]. The study was time limited due to the contractual agreements with the DWP. A more detailed understanding of the emergent themes could have been undertaken if the study had been extended. The study would have been improved had we used real as well as simulated consultations to explore some of the complexities of the consultation. However, due to time limitations applying for ethical approval to use such methods was not possible.

The study employed both action research and focus group methodology. Focus group methods were employed in the development of the groups but action research utilized the group to help shape subsequent meetings. This study aimed to explore the GPs' 'actions' and 'interactions' in the consultation rather than their attitudes to the processes of certification. The strength of this study was that the methods employed enhanced engagement of the participants who moved from an initial position of resistance to active change talk in Meeting 3 about how the consultation could be improved. It used behaviour change methods to engage the GPs to consider what they 'do' in the consultation and 'why' rather than their attitudes to process. This allowed practitioners to reflect on their own practice and made comparisons with other challenging consultations.

Studies to date that have examined attitudes to work, health and sickness certification have looked primarily at the process of certification and the difficulties practitioners encounter in their practice. Hussey et al. [1] looked at how GPs operated the certification system. Their study showed that GPs struggled with the systems and the process that they perceived failed to address complex problems. It also addressed GPs' feelings around doctor–patient conflict when managing the certification process. Hiscock and Ritchie [2] set out to explore GPs' roles and attitudes to the certification process. Von Knorring et al. [5] concluded that leadership and management were important factors that contributed to GPs' certification practices. This study moved beyond GPs' attitudes to the process and systems of certification and explored GPs' perceptions of the interactions that occur within the consultation about work and health.

This study starts to unravel the complexity of the GP consultation about work and health and recognizes the skilful negotiation that is required to manage this effectively. It illustrates how GPs struggle with the 'importance' of their role and 'confidence' in managing the consultation about work and health. It shows that in spite of GP training to place the patient at the centre of the consultation and develop a management plan, this was generally not the case when considering the work and health agenda and sickness certification. The educational programme sick note or bust attempted to address the issues of both importance in considering the work and health consultation and the confidence practitioners require to manage the interaction effectively. Importance and confidence are important characteristics of change [10,14,15]. Addressing these characteristics in an online educational programme was the aim of the second phase of this study, which set out to investigate whether it is possible to alter GPs' attitudes to the work and health consultation. The findings will be reported in a further paper. In 2007, The Royal College of General Practitioners piloted National Education Health and Work workshops across the UK [16] which were informed by the results of this study. These provided GPs with a 3-h face-to-face training session and followed similar principles of addressing importance and confidence. These workshops were commissioned by the DWP and independently evaluated [14,17]. The workshops were reported as effective and valued by GPs and are to be rolled out across the UK in 2009.

Key points

- Studies to date have examined general practitioner attitudes to sickness certification processes.
- General practitioners struggle with the importance of their role and confidence in managing the consultation about work and health.
- In general, general practitioners do not consider the work and health agenda as part of their management plan.
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Conflicts of interest

M.A. commissioned the project to develop an educational programme while he was the Chief Medical Officer at the DWP. M.A. retired from this role in 2005 and took up his role as a Professor at Cardiff University. D.C. and S.R. declare that they have no competing interests.

References