

Exploring how General Practitioners work with patients on sick leave

(A study commissioned as part of the 'Job Retention and Rehabilitation Pilot' evaluation)

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The purpose of this study was to explore general practitioners' (GPs') approaches to managing sickness absence and to assisting patients to return to work. The objectives were to explore the roles they play, their perception of the extent of their remit, the types of discussions they have with patients, the factors that influence their approaches and how they work with other specialists or organisations. The study involved in-depth interviews with 24 GPs.

Key findings

- GPs dealt with sickness absence on a daily basis, and held the view that patients seeking sickness certificates were almost always genuine.
- GPs said that most cases were relatively straightforward in that there were tangible symptoms and a clear clinical pathway, such as acute episodes or chronic conditions, and post-operative recovery. GPs also described conditions which were harder to manage and where recovery time was difficult to predict, such as back pain, stress, depression and anxiety.
- GPs said that patients behaviour and motivation was influenced by issues such as subjective reactions to the experience of illness, organisational culture and financial circumstances.
- GPs generally felt that a return to work can be of benefit to patients for a range of physical, social and psychological reasons. This view was qualified where work was poorly paid and of low status and where the job itself caused or exacerbated the illness.
- GPs saw some key constraints on their role in helping patients return to work. They talked about the limited time they could spend with a patient, and the difficulty of balancing the relationship of trust with patients with the obligation to the benefits system and employers. They also described having limited Occupational Health expertise, and difficulties in providing continuity of care.
- GPs' approaches to discussing a return to work fell into three broad categories. The most proactive GPs described detailed discussions with patients about returning to work. The least proactive described no discussion of work, or limited discussion only if the patient raised it or the absence was clearly unmerited. In between were GPs who discussed work less emphatically than the first group, and who did not proceed if they met with resistance from the patient.
- While GPs made extensive referrals to other services within their own clinics and the wider NHS, it was rare for these to have a work rehabilitation focus.
- GPs reported limited awareness of the kinds of services provided by Jobcentre Plus, and a widely held view that there were no other services providing vocational rehabilitation.

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Influences on the management of sickness absence

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

There was a widespread view among GPs that work can be of therapeutic benefit for a range of physical and psycho-social reasons. This view was qualified however where patients worked in low paid jobs of low social status, and where the job itself caused or exacerbated a physical or psychological condition. GPs' own personal views about the value of work, as well as observations of patients and research, were influential here.

Four key factors were identified, to varying degrees across the sample, as constraints on GPs' involvement in return to work issues. GPs stressed the importance of preserving the doctor-patient relationship, based on mutual trust and on an assumption that the doctor is acting in the patient's best interests. GPs sometimes saw a conflict between their obligations to patients and to either the benefits system or employers. Shortage of time also made it difficult for doctors to address work thoroughly, and there were references to the new GP contract not funding work rehabilitation activity. GPs felt their limited occupational health expertise made it difficult to give advice about the interaction between a condition and work, and there were some concerns about litigation. Finally, doctors highlighted the difficulties in providing continuity

of care and building up in-depth knowledge of a patient.

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

Managing sickness absence

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

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

There appeared not to be a return to work dimension to doctors' clinical treatment of patients either themselves or in terms of NHS referrals. Indeed they strongly emphasised the importance of equality of treatment and felt that providing treatment on the basis of working status would

be wrong. There were some reports of working more proactively with patients with a job to return to, or making referrals with a higher degree of urgency, but in general work issues appeared not in themselves to influence clinical treatment decisions.

There were a range of strategies for addressing patients' motivations to work. GPs talked about suggesting, encouraging, questioning or challenging patients, with varying degrees of firmness. Sickness certification was sometimes used actively to manage patients' expectations and the timescale of their return to work, where GPs gradually shortened the duration of certificates or warned the patient that they were on their penultimate or last sick note. There were different approaches to using Med 3 forms for a phased return. Some GPs used them to inform employers that the patient could return on a phased return or signed the patient back on a part time basis, but there was also a view that it was only possible to certify patients as able to resume work on the basis of their full duties.

GPs took different approaches to liaising with employers and providing reports. One group of GPs saw initiating or responding to contact as an opportunity to recommend ways in which the patient could be supported in returning to work. But there were concerns about such contact and doctors generally encouraged patients to take the lead. Time, confidentiality and potential conflicts of interest were relevant here.

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

The most proactive group of doctors described detailed discussions of work with patients, often from early on, and included doctors who initiated contact with employers. Some here stressed their use of iterative, persuasive, in-depth communication addressing patients' concerns;

others seemed to be more ready to use sickness certification or referrals for PCAs to reinforce their own messages. The least proactive group of doctors described no discussion of work or limited discussion, either when the issue was raised by patients or in rare circumstances when the absence was flagrantly illegitimate. In between were doctors who discussed work to some degree but who would not proceed if they met with resistance from the patient. They described raising work so that the patient was clear about their options but felt the extent to which they could persuade or help was limited.

Working with others

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

Despite the fact that GPs often saw at least some limitations to their own involvement in work rehabilitation, the idea of additional specialist services met with mixed reception. There was sometimes strong support for the idea but others doubted that specialist provision would add much or that patients would use it, and it was clear that for some working with such a service would not be a priority.

Conclusions and recommendations

If GPs are to be encouraged to place more emphasis on work rehabilitation then several strategies could be considered further:

- Reinforce messages about the therapeutic value of work and raise awareness about the financial support available to make work pay.
- Address assumptions about how far work can be promoted within a constructive doctor-patient relationship. This might involve educative work to support GPs' negotiating skills and identify strategies for communicating with patients. An alternative approach would

be to introduce a more structured and prescriptive approach to GP consultations.

- Increase occupational health training for GPs.
- Emphasise work rehabilitation in GP contracts and provide funding incentives for it.
- It may be worth considering whether certification should become an optional, and separately funded, aspect of their work although this may not be feasible and clearly would not be consistent with holistic models of primary healthcare.
- Support GPs' work with employers by promoting effective strategies and examples of good practice, joint training sessions, and using sickness certification documentation more consistently to make recommendations to employers. Improving employer practice would also be important to raise the credibility of employers and of working with them among GPs.
- The data suggest there is a role for specialist work rehabilitation services particularly to provide assessments of capability and the occupational implications of conditions; advice about graded returns and alternative job routes; mediation between employers and employees; faster access to clinical help, and a more work rehabilitation focus to specialist health care.
- Finally, there is clearly scope to raise awareness of the role of Jobcentre Plus as the distance between GPs and DWP is striking.

The full report of these research findings is published for the Department for Work and Pensions by Corporate Document Services (ISBN 1 84123 840 6. Research Report 257. June 2005).

It is available from Paul Noakes at the address below.

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