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Elaine Sylvia Wainwright

A thesis submitted for the degree of Doctor of Philosophy

University of Bath

Department for Health

February 2013

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Epigraph

“Our bodies are made of ideas as much as of flesh”

What I Loved by Siri Hustvedt
Abstract

The aim was to elucidate the social construction of chronic pain as a cause of work absence in the UK, focusing on negotiation of sickness certification and return to work, in the context of recent policies to tackle rising sick-listing rates, including a national educational programme about the health benefits of work, and introduction of the ‘fit note’.

Following a literature review, two qualitative studies were conducted from a symbolic interactionist perspective. The first comprised semi-structured interviews with doctors and chronic pain patients, leading to a second study in which employers and employees with chronic pain were interviewed. Interviews were transcribed verbatim and analysed according to constructivist grounded theory principles.

The first study revealed tensions in the doctor-patient relationship as the process of sickness certification was negotiated. The indeterminacy of chronic pain rendered the biomedical approach to diagnosis and assessment of capability for work problematic, while a shift to the psychosocial model could generate feelings of invalidation in patients. A wide range of moral and socio-cultural factors was invoked by doctors and patients to contest sick-listing decisions.

The second study identified difficulties that can emerge when chronic pain patients return to work. Employees discussed how managers failed to understand their problems or make sustained adaptations; employers reported difficulty reconciling the needs of employees with organisational imperatives and argued that employees and doctors colluded in sanctioning low resilience. All stakeholder groups supported the fit note’s focus on capacity not incapacity, but were skeptical about whether it would surmount the tensions and difficulties that arise in sickness certification and return to work for chronic pain patients. Struggles for meaning and construction of identities are difficult for policy to address, but deeper understanding of the processes behind them and rich accounts of stakeholders’ views, may nudge the system towards more appropriate responses.
Publications and Conference Presentations

Heaver, E. and Wainwright, D. (2009) "Interpreting the rights in the NHS constitution" *BMJ* vol 338 pg. 428


Wainwright, E., Wainwright, D., Keogh, E. and Eccleston, C. (2011) Fit for purpose? Using the fit note with chronic pain patients: a qualitative study. *Br J Gen Pract* 61 (593) pp.794-800 (or *Br J Gen Pract* 2011: DOI: 10.3399/bjgp11X6133133) *(This article, for which I am lead author, has been chosen by the journal editor as an exemplar of qualitative research for an online critical appraisal system they are developing for researchers, reviewers and GPs internationally BJGP has impact factor of 2.07 and is second most cited journal of GP and primary care in the world).*


British Sociological Association Medical Sociology Group 42nd Annual Conference, University of Durham, Sept 2010 – The Social Negotiation of Sickness Certification for Chronic Pain Patients (oral presentation)

British Pain Society April 2010 – Narrative Review: What do we Know About Sickness Certification for Chronic Pain Patients? (poster)
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<th>Description</th>
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<tbody>
<tr>
<td>ACAS:</td>
<td>Advisory, Conciliation and Arbitration Service</td>
</tr>
<tr>
<td>ARMA:</td>
<td>Arthritis and Musculoskeletal Alliance</td>
</tr>
<tr>
<td>BMA:</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>BPS:</td>
<td>British Psychological Society</td>
</tr>
<tr>
<td>CBI:</td>
<td>Confederation of British Industry</td>
</tr>
<tr>
<td>CIPD:</td>
<td>Chartered Institute of Personnel and Development</td>
</tr>
<tr>
<td>CPD:</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CRPS:</td>
<td>Chronic Regional Pain Syndrome</td>
</tr>
<tr>
<td>DCS model:</td>
<td>Demand-Control-Support model</td>
</tr>
<tr>
<td>DOccMed:</td>
<td>Diploma of Occupational Medicine</td>
</tr>
<tr>
<td>DWP:</td>
<td>Department for Work and Pensions</td>
</tr>
<tr>
<td>EBM:</td>
<td>Evidence based medicine</td>
</tr>
<tr>
<td>ESA:</td>
<td>Employment and Support Allowance</td>
</tr>
<tr>
<td>EUC:</td>
<td>European Union Commission</td>
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<tr>
<td>GDP:</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GMC:</td>
<td>General Medical Council</td>
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<tr>
<td>GP:</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GTMs:</td>
<td>Grounded Theory Methods (after Charmaz, 2006)</td>
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<tr>
<td>HR:</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HSE:</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>HWWB:</td>
<td>Health, Work and Well-being Strategy Unit</td>
</tr>
<tr>
<td>IAS:</td>
<td>Independent Assessment Service</td>
</tr>
<tr>
<td>IASP:</td>
<td>International Association for the Study of Pain</td>
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<tr>
<td>IB:</td>
<td>Incapacity Benefit</td>
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<tr>
<td>JSA:</td>
<td>Jobseekers’ Allowance</td>
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<tr>
<td>LFS:</td>
<td>Labour Force Survey</td>
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<tr>
<td>LREC:</td>
<td>Local Research Ethics Committee</td>
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<tr>
<td>MPQ:</td>
<td>McGill Pain Questionnaire</td>
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<tr>
<td>MUS:</td>
<td>Medically unexplained symptoms</td>
</tr>
<tr>
<td>NHS:</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NI:</td>
<td>National Insurance</td>
</tr>
<tr>
<td>NICE:</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>OH:</td>
<td>Occupational Health</td>
</tr>
<tr>
<td>ONS:</td>
<td>Office of National Statistics</td>
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<tr>
<td>PCA:</td>
<td>Personal Capability Assessment</td>
</tr>
<tr>
<td>PCRN:</td>
<td>Primary Care Research Network</td>
</tr>
<tr>
<td>QOF:</td>
<td>Quality and Outcomes Framework</td>
</tr>
<tr>
<td>R and D:</td>
<td>Research and Development</td>
</tr>
<tr>
<td>RCGP:</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>SME:</td>
<td>Small and medium enterprises</td>
</tr>
<tr>
<td>SSP:</td>
<td>Statutory Sick Pay</td>
</tr>
<tr>
<td>WCA:</td>
<td>Work Capability Assessment</td>
</tr>
<tr>
<td>WHO:</td>
<td>World Health Organisation</td>
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<tr>
<td>WRAG:</td>
<td>Work Related Activity Group</td>
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Chapter One: An Overview of the Thesis

1.1 The aim of the thesis

Meeting the needs of those who are too sick to work has always been a cornerstone of the British welfare state, but policies for the provision of sick pay and health care have long been accompanied by a counter narrative emphasising moral hazard, malingering and illness deception. There may be a broad consensus that those who can work should and that those who cannot should be provided for, but differentiating between the two has proven a more complex task than political rhetoric often implies, particularly for conditions like chronic pain where evidence of physical capacity is often a poor guide to the capacity for work. Successive UK governments have introduced policies to curb the growing rates of sickness absence, but such policies are conceived in abstraction from the lived reality of the doctor’s consultation room where the decision to issue or withhold a sick note must be negotiated under conditions of uncertainty.

The aim of the thesis was therefore to describe and elucidate the social construction of chronic pain as a reason for work absence in the UK, focusing on stakeholders’ micro-interactions of the negotiations of sickness certification and return to work, and how these interact with macro considerations such as policy, social norms and the organisation of medical knowledge. This aim was tackled by engaging with several different bodies of literature, most obviously that concerned with sick-listing, but also research about work, pain and health, health, the doctor-patient relationship, as well as policy-making and implementation around sick-listing. I studied research from the UK and countries with relatively similar sickness certification systems to ours (mostly European). Two empirical studies were conducted and their findings were synthesised with insights from the existing literature to develop a theoretical framework which elucidates the processes by which sickness certification for chronic pain patients is constructed.

The research questions were designed to how GPs and patients describe their experiences of sickness certification for chronic pain, studying the difficulties they face and the strategies employed to address these. I also researched their attitudes and beliefs regarding several policy initiatives implemented by the last UK Labour government in 2010 and continued by the current coalition government to try to reduce sick-listing rates (i.e. the fit note and a national education programme on work, health and well-being). Similar research questions were studied for employers and employees (as not all patients are in work), considering their aspirations and expectations regarding how sick leave and return to work processes are negotiated, how they felt they interacted with the sickness certification consultation, and their views on the fit note. Sick notes and fit notes are both medical statements; the fit note is properly known as ‘the statement of fitness for work’ but documents rarely use this phrase. I use the common terminology of sick note and fit note during the thesis.

1.2 Work and pain

In chapter two, I address whether work is good for our health and well-being, and specifically whether it is good for chronic pain patients. I consider what kinds of activities are meant by “work” and also how to define “chronic pain”, showing that both these concepts are complex.

I discuss the evidence for the claim that work leads to positive health outcomes for most people, including most chronic pain patients suffering from musculoskeletal disorders. There are important caveats to this claim which are largely lost in translation from research to policy, and there is little evidence about the relationship between work and health for sufferers of chronic pain not grouped under “musculoskeletal disorders”. An important issue is that work has an objective reality, but also a subjective dimension, as people’s perceptions of it and how they behave in response to it are shaped by
psychosocial factors. Similarly, chronic pain may have an objective reality if there are biological correlates such as a slipped disc, but there is no objective measure for pain; it is essentially a subjective phenomenon and people’s responses to it are influenced by psychosocial variables. Hence, it is useful to adopt a biopsychosocial approach to considering how the relationship between pain and work is mediated by consciousness, and how such mediation is an important dimension in the sick-listing process.

I argue that sickness absence has been constructed as a negative event which promotes disengagement from work and disability, and that this makes sense in the context of evidence that work is good for most of us and also of rising incapacity benefit rates. However, I suggest that sick leave can be a much-needed time for repair and recovery, and that this construction of it is diminished in current rhetoric and policy around work, health and well-being. Thus policy initiatives such as replacing the sick note with the fit note, and an educational programme on the benefits of work, aim to get almost everyone back to work, but it can be difficult for a doctor to decide if a particular patient would be better off on sick leave or at work. It can also be difficult for the patient to decide, and for employers to know how to respond to sickness absence. I also consider how the complexity of defining and managing chronic pain exacerbates the negotiations within the sick-listing consultation and also within return to work processes more generally. I conclude that work can be both good and bad for pain and health. The complexity arises in judging which it will be for an individual, hence the importance of sickness certification as a process and the difficulty of getting it right.

1.3 The problem of sickness certification for chronic pain

The conceptual literature review in chapter three considers what is already known about sickness certification for chronic pain patients and why it is such a problematic process. The literature highlights problems with the way sick-listing data are collected. Despite these concerns, the data that we do have show the magnitude of the sick-listing problem. The data also show useful information about demographic factors that correlate with sickness certification rates in the general practice consultation. These include the gender of the doctor and patient, as well as interactions between the two, doctors’ and patients’ ages, and doctors’ years of experience. Research has also considered how protagonists are influenced by wider structural factors such as available medical facilities (doctors) communities’ cultural norms around taking sick leave (doctors and patients) and views on job satisfaction and social support (patients). However, I argue that studies which model such determinants, whilst useful, often have weak predictive power and can be hard to interpret theoretically. Other researchers have come to similar conclusions, and suggested that we need to engage with doctors’ and patients’ beliefs. I discuss what is known about how patients’ and GPs’ beliefs interact with sick-listing. For example, sick-listed patients hold greater fear avoidance beliefs about work than non-sick-listed (Morris and Watson, 2011) and a recent review by Main et al. (2010) concluded we need to know more about how to elicit and manage pain patients’ beliefs. Some studies have shown that doctors’ beliefs about how far back pain sufferers should avoid movement affect their sick-listing decisions whereas others do not (for example, Werner et al. 2012 and Watson et al. 2008 respectively).

Only so much can be understood by looking at what doctors and patients bring to a consultation, because sick-listing is also affected by how stakeholders construct meaning in micro-interactions within the consultation, so we need to study this process of negotiation. How patients and doctors communicate pre-existing constructs of meaning and how they generate new ones through interaction, is important. For example, GPs' understanding of patients’ descriptions of working conditions, and patients’ experiences of GPs’ responses to their descriptions, affect sick-listing. Doctors also discuss the conflict they report experiencing between themselves and patients, other healthcare professionals and the Government. Less has been written about patients’ views but they also report
feeling in conflict with their doctors and transgressing societal norms of resilience over the capability decision. The contestability of many chronic pain conditions worsens the uncertainty over assessing workability.

I conclude that there are several problematic outcomes from the sick-listing process, including patients feeling delegitimised whether or not they are sick-listed, simply from having experienced the process, and doctors feeling pressurised into giving sick notes. There is more research on doctors’ views than on patients’ but we still lack in-depth understanding of how and why doctors make decisions, and we lack knowledge of patients’ constructions of meanings around sick-listing. We particularly lack knowledge of these processes with regard to chronic pain patients. Relevant research questions are suggested to contribute to these knowledge gaps. Finally, I suggest that the construction of sickness certification in policy terms may have been overly simplistic, in assuming that sick-listing rates are mainly a function of loose gatekeeping on the part of the doctor. There is good evidence behind this view, although important provisos to it as well. The next chapter considers the policy response in detail and how it may or may not account for the complexity of sickness certification interactions.

1.4 The UK policy response to rising sickness certification rates

Chapter four begins by considering policy implications for sickness certification from the major reviews on work and health commissioned by the UK Labour government (in office from 1997-2010) and also by the subsequent coalition government, which has continued Labour’s implementation of the reviews’ recommendations. I discuss how sickness certification might be affected by two major elements of the current policy designed to reduce sick-listing: the national education programme on work, health and well-being, with specific sections on sick-listing, and the change from sick note to paper and electronic fit note. I evaluate the evidence so far concerning how these new policies are working, examining what the policy approach includes, and crucially, what it omits.

The policy response has moved beyond a knowledge deficit model towards more understanding and practical training on how to manage areas of conflict within sickness certification. However, I argue that this journey has been too slow and the policies do not satisfactorily address several key issues. These include: the difficulties of applying evidence-based knowledge in practice, even if the will is there; the need to preserve the doctor-patient relationship whilst also challenging many patients’ beliefs about work and health; issues of who has power and status over whom leading to conflict between all stakeholders (doctor, patient, employer and government); and how doctors and employers struggle with the subjectivity of both capability decisions and chronic pain.

I conclude that some of the issues may be teething troubles, expected with any policy initiative, but that there are more fundamental limitations to the policy approach which need to be considered. I highlight some of the ways in which medical sociology might complement existing knowledge about, and work towards improving, sickness certification, which the next chapter considers in detail. I end by adding some new research questions, based on the knowledge gaps discussed in the chapter.

1.5 Sociological critique

The aim of chapter five is to use sociological concepts and theories to critique the dominant policy perspective in relation to sickness certification. ‘Naive rationalism’ is posited as the dominant model of policy-making in the field of sickness certification and return to work. This approach comes from evidence based medicine (EBM) and the biomedical model, and is largely positivist and reductionist in the type of evidence it accepts. It overlooks the social i.e. the role of meaning and its social negotiation. It also overlooks issues of knowledge, power and social control. I consider how concepts from medical sociology may complement the way in which sickness certification is framed in
policy-making. There is some sickness certification research that includes medical sociological concepts but these are lost in translation to policy. The first of these is the Parsonian sick role, which unlike current policy-making, recognises the role of norms, values and expectations in the sick-listing consultation. The sick role retains functionalist assumptions about consensus between doctor and patient, i.e. the doctor has power, and in this way overt conflict between the two is minimised. At first glance, this does not sit well with much sick-listing research, in which conflict is emphasised. However, I discuss how modern notions of concordance and mutuality in the doctor-patient relationship have weakened the Parsonian notion of the doctor having ultimate power and the sick role is still potent within this context, although more contested. There is also some debate about how the sick role can apply to chronic, fluctuating conditions, but Parsons himself, as well as others (e.g. Bury (1982) showed how people suffering from chronic ill health can cyclically enter and leave the sick role. As something which patients invest effort to attain, and about which doctors feel wary, sickness certification policy would do well to consider the meaning of and struggle for the sick role. Policy does not have to use the language of medical sociology, but could still discuss why patients the doctor does not think need sick-listing might want a sick note; it can be nobler to be sick than to be unemployed, for example, (Barnes et al., 2008) and it is helpful to make doctors more aware of psychological and social reasons for seeking sickness certification.

Similarly, policy could recognise the influence of stigma on sick-listing and return to work issues for chronic pain patients. There is an established body of work showing that chronic pain patients are subject to stigmatisation in our culture, both in general and specifically in terms of return to work processes. I discuss Goffman’s conceptualisation of stigma and how chronic pain patients do indeed adopt the covering and passing strategies about which he theorised. Further, their families become subject to courtesy stigma and all of these facets propel many chronic pain patients to want the legitimacy of formal entry into the sick role. Alternatively, people may go back to work before they feel well enough in an attempt to become reintegrated, which may only result in phantom acceptance by the ‘normals’. Policy alone may not be able to change stigmatisation, but could acknowledge it as an issue: it may be useful to appropriately pressurise some people back to work but may also work against positive health outcomes for many others.

I discuss Foucault’s point that despite the curative power of biomedicine, it is a particular way of seeing, which shapes how problems are constructed and possible solutions considered. These constructions are not neutral in terms of the exercise of power. Furthermore, the value attached to biomedicine is such that its authority can extend beyond its range of application. For sick-listing, the capability decision may be based on social and cultural factors that lie beyond the biomedical domain, but the doctor’s status as a practitioner of evidence-based medicine can lend his or her decisions an authority that might not otherwise be accepted.

I discuss that Foucault’s conception of medical knowledge as a discursive formation illuminates how power and knowledge are intimately bound up together. Foucault’s notion of power as being constituted in the micro-interaction between the doctor and patient is because of the way in which both doctor and patient are constrained by medical knowledge and discourse. Biomedicine constructs the body so that doctors have power over it, but they must also respond to it as experts, which can be difficult when faced with chronic pain conditions and the capability decision, neither of which fit the objectification of the biomedical model. However, Foucault underplays the notion of agency, arguing that we are constituted by discourse, and are always inside one discourse or another. This leads into the work of Bourdieu, and habitus, as a meso-level concept which mediates between micro-interactions and structural forces constraining us.
Bourdieu's contribution to the structure-agency debate is that we have habitus, or dispositions to behave in certain ways in different situations. Habitus can belong to an individual, with all the socially negotiated meanings about their roles in life that are important to them, and can also be strongly group-based e.g. Bourdieu argued that there is a habitus of being a school child, that affects how a pupil behaves, and that the student may behave differently in another context (Bourdieu, 1984). Habitus is both individual and collective, as there is an interactive relationship between personal agency and social structures; each can influence the other. In this way, habitus bridges micro-individual accounts and socio-ecological accounts of sickness absence. It considers how social norms bear down on an individual but also how they may stand up to this pressure and do something unexpected, perhaps not without social censure, but also perhaps changing the pressuring agent. Some of the sick-listing literature discusses the effect of employee habitus on both patient and even doctors, who respond to work communities’ values. Habitus thus gives a context for negotiation in general practice consultations. Some reviewers comment that we need to consider organisational systemic issues and how they affect individuals, so habitus appears a useful concept to enhance what we know about the challenges of sickness certification.

Drawing the strands together, I conclude that there is a need for a different ontological and epistemological standpoint than naïve rationalism. We need to study the social negotiation of meaning in the doctor-patient relationship, as well the employer-employee axis, and consider how knowledge and power affect and might be affected by micro-interactions within the consulting room and the workplace. This establishes the theoretical standpoint that informs the methodology for the two empirical studies reported in chapters six to nine. The next chapter justifies in detail the choice of symbolic interactionism and its empirical arm, grounded theory, as the chosen methodological framework.

1.6 Rationale for the methodology for studies one and two; application to study one

Chapter six is the main methodology chapter which describes and justifies the ontological and epistemological choices made for both the empirical studies, as these were the same. These choices resulted from the nature of the phenomenon under study, as revealed by the literature and reflections on it presented so far. Briefly, the previous chapter showed the method would need to enable study of how participants negotiate meaning in social relationships. Symbolic interactionism was chosen as the methodological framework as its epistemology asserts that there are social realities which can become known, through observation, including interviews. Its ontology asserts that social order is maintained at the micro level of social interaction in everyday life, i.e. that such interaction is how we make sense of the world and invest our experiences with meaning. This is not simply the imposition of previously existing narratives, but a dynamic process in which meanings are negotiated, shared and reworked. This fits well with the concept of habitus. Grounded theory methods (GTM) were chosen to analyse the data as its epistemology posits that there are categories which help us to understand the assumptions informing individual realities; this makes a shared creation of social reality possible. It is argued that individual realities are expressed through human interaction, which can be observed. I also chose GTMs as opposed to other interpretative approaches such as discourse analysis or phenomenology to enable construction of explanatory theory from data, rather than to study how people use language to enact identity or to describe how phenomena are represented in consciousness, the central goals of discourse analysis and the phenomenological approach respectively (Starks and Brown Trinidad, 2007).

Having justified the methodological approach, I report the following for the first empirical study: the research questions, sampling and recruitment strategy, inclusion and exclusion criteria, details of who was recruited, data collection and analysis decisions and NHS and University ethics and research governance approvals gained. Chapter eight
reports these details for the second empirical study. The research design for each study was similar, comprising a set of semi-structured interviews with individuals, either face-to-face or over the telephone. The first empirical study compromised interviews with 13 GPs and 30 patients. The interviews were audio-recorded, transcribed and analysed according to constructivist grounded theory principles.

1.7 Results for study one: the doctor-patient dimension

Chapter seven reports the results of the GP and patient interviews. The results are divided into three main areas; enacting the role of the ideal doctor, similarly the ideal patient, and participants’ experience and views of the policy response to sickness certification.

The non-specific nature of chronic pain exemplifies a tension in the discourse of general practice between the traditional model of clinical science and the newer biopsychosocial approach. General practice is often about managing medically unexplained symptoms, and findings from interviews with doctors did not suggest that sick-listing for chronic pain is harder than for other, sometimes subjective conditions which may also partly rely on patient report, like depression. However, many doctors found the uncertainty of assessing pain was challenging as a key part of this was patient enactment, which depends on patients’ articulation and doctors’ interpretation. Similarly, the unexplained nature of some chronic pain conditions made sick-listing challenging, as doctors wanted more objective information about both pain and work before having to make a practical decision. Doctors also discussed how societal factors such as the organisation of work and rehabilitation services influenced their decisions and made them feel they were less than ideal doctors as they could not help patients with these elements, leading to possibly poorer outcomes. Similarly, conflict with patients over sick-listing disrupted the Parsonian ideal of the caring, sympathetic doctor and challenged doctors’ views of their knowledge base. Doctors also felt the Government is asking them to police the benefits system whereas that is not what doctoring should be about. Such policing involves making moral judgements with which doctors felt uncomfortable.

Patients reported that the uncertain nature of chronic pain made sick-listing challenging; they were confident they would eventually get a sick note if they wanted one, but felt delegitimised by the process. They felt their accounts of their pain and knowledge of their workplace were not fully trusted by doctors or indeed by others, such as colleagues, neighbours, and the Government. They also perceived that their choices within the healthcare system were limited, forcing them to behave in certain ways, such as trying to see a doctor when their pain was severe, and enacting severity if the consultation occurred during a period of better health. They perceived that GPs departed from the ideal doctor role as conflict was not seen as something that should occur in a consultation. Less conflict occurred if patients wanted to work whereas GPs preferred to sick-list, as this posited participants as Parsons’ ideal resilient patient and caring doctor.

Issuing a sick note can be a symbolic act that partly re-establishes the social order of the clinic. This is a symbolic interactionist concept sensitising researchers to ways in which order in complex interactions, such as doctor-patient consultations, has to be reconstituted continually, using implicit and explicit rules about status and power. Issuing a sick note went some way towards restoring the social order in the consultation. Doctors simultaneously enacted sympathy whilst making patients engage with elements of their gatekeeping role; patients received a state-sanctioned sick role status. However, the note could leave both parties dissatisfied. Patients were worried about going through a difficult enactment again if they want to extend their sick leave; doctors were aware that gaps in their knowledge base were being exposed and biomedical authority remained challenged by occupational and psychological elements of sick-listing.
The policy response was broadly welcomed in that participants agreed with the concept that work is good for us. However, some felt patients were being pressurised by this norm into returning to work before genuinely sustainable and that poor working conditions meant doctors would allow sick-listing to continue in many cases. Participants liked the fit note’s focus on capacity but both doctors and patients blamed employers for failing to comply with its recommendations. Hence they felt powerless to change matters, even when they wanted to. Participants thus felt constrained by forces external to the consultation and that they were unfairly blamed for sick-listing rates whereas in fact we need broader cultural shift towards less judgement of those suffering chronic conditions, and towards creating positive workplaces. The next study begins to unpick employers’ views on sick-listing and return to work. I also interviewed employees, as only half the patients in this study were in work, and whereas this study focused on the general practice consultation, the next focuses on employees’ experiences within the workplace, arising from being sick-listed.

1.8 Application of methods for study two: the employer-employee axis

Having justified the methodological approach in chapter six, this chapter reports the following details of the second empirical study: the research questions, sampling and recruitment strategy, inclusion and exclusion criteria, the sample, data collection and analysis decisions and University ethical approvals gained. Thirteen employers and 13 employees participated in individual semi-structured interviews, either face-to-face or over the telephone. As for study one, the interviews were audio-recorded, transcribed and analysed according to constructivist grounded theory principles.

1.9 Results for study two: the employer-employee axis

Chapter nine reports the results of the employer and employee interviews. Five main sections reported the following core themes. Firstly, I consider whether interviewees thought the GP-patient sick-listing consultation influenced workplace management of sick leave. Employers felt they had limited power against both doctors and patients, who acted in collusion to sign people off too readily and did not supply the workplace with appropriate detail. Such omission affected their confidence in how they responded to sick leave, often making them cautious. Employees saw power relations very differently, reporting that they were unable to make those employers who ignored GPs’ information take it into account, and this failure was what damaged return to work processes.

Secondly, the research questions asked employers whether they thought they should or could influence the GP-patient interaction. Most reported that did not think they could, partly due to social norms sanctioning low resilience. They wanted to wield influence via better communication with doctors, which they felt would reduce what they termed inappropriate sick-listing.

Thirdly, employees were asked whether they thought employers should or could influence sick-listing. Employees reported employers ought to do so positively, by collaborating with doctors, but that they actually do so negatively by stigmatising chronic pain sufferers. Evidence from employees suggested stigma persists even in periods of good health, so their social identity was spoiled and needed attention as much as their physical functioning. This led into the fourth section, which considered how sick-listing challenges the habitus of what it is to be an ideal employee as well as an ideal boss. Managers were caught between competing narratives of some sympathy for employees' suffering versus suspicions people lack resilience, coupled with pressure to run a business; workplace norms did not appear to accommodate chronically and variably ill people, as such fluctuations violate being an ideal patient (i.e. one who recovers and stably returns to work, according to classical sick role theory).
The final section considered whether the fit note could improve some of these difficulties. The results suggested that its appreciation of a continuum of fitness might assist the fluctuating nature of chronic pain, and both employers and employees liked the positive principles behind it, which went some way to restoring spoiled identities by opening up dialogue about capacity rather than incapacity. However, both groups experienced practical problems with implementing its suggestions, and that it did not improve stakeholders’ perceptions of powerlessness discussed in the first results section of this chapter.

I conclude that current sick-listing and return to work systems are difficult to apply when someone is suffering from chronic pain. There were not only practical difficulties, but each party felt powerless in the face of the other’s domain of knowledge: on some occasions medical knowledge was seen to be privileged, of which employees tended to approve, and on other occasions occupational knowledge was valued, which most employers preferred. Most participants reported they wanted three-way collaboration between employee, doctor and employer, but were impeded by mistrust of others’ agenda, and Foucauldian discursive formations (chronic pain’s resistance against biomedical definition, the organisation of healthcare, workplace rules, as well as social norms about what it is to be resilient). The discussion chapter next takes all these strands, in conjunction with study two’s results, to draw together insights and suggestions for the future.

1.10 Discussion
I propose a theoretical framework for understanding the complex process of sickness certification, synthesising the empirical findings, literature reviews and the sociological critique of naïve rationalism discussed in chapter five. I suggest analytic propositions characterising the social relations and mechanisms underpinning the grounded theory. I consider the processes occurring during the consultation, using habitus as a mediating factor between the micro-interaction within the consultation and macro influences upon it. There is little research which applies Foucauldian concepts of the intertwined nature of knowledge and power to sick-listing for chronic pain, and I attempt to use these ideas to explore its intricacies. I discuss stakeholders’ experiences of balancing different return to work imperatives, showing the interaction, and conflict, between medical and workplace habitus. I then discuss the limitations of the thesis stemming from issues such as the sample composition and size. However, I discuss how I have embedded my findings in a thick description of context, and tried to be reflexive about my methods, so that readers can assess the plausibility and transferability of my conclusions. Finally, I make some recommendations for policy and practice and suggest an agenda for future research.
Chapter Two: Work and Pain

Introduction

Work and pain are often bound together in the English language. Labour can refer to both work and childbirth, evoking images of effort and pain in both instances. “Travail” also encapsulates ideas of work and pain in one word. It means “painful or laborious effort” (Oxford Dictionaries Online, 2012). Its precise etymology is obscure but is known to stem from mid-thirteenth century Old French “travail” meaning “suffering; painful effort”. This in turn came from various vulgar and literary Latin routes including the Medieval Latin “trepalium” meaning “instrument of torture”. Its duality captures some of the fundamental issues of this thesis: is work good for people, including chronic pain patients, or does it exacerbate or even cause painful problems? Can the same job do both, depending on the many factors which make up the worker and their working environment? How can protagonists involved in sick-listing and return to work processes decide upon the meaning of work and how might this impact on sickness certification?

There is compelling evidence that work which occurs in physically and psychologically “safe and accommodating” environments is good for our health and well-being (Waddell and Burton, 2006, p. ix). It can be the emollient which smooths over financial, psychological, social and physical ills; it can offer pain relief, encouraging movement to stop one’s back from seizing up, providing distraction, money and social networks (ibid; also Black, 2008). Yet work can be bodily painful if physical risk factors are not controlled (Sim et al., 2006) and psychologically challenging if employees experience stressors such as task overload, relationship breakdown, or job insecurity (Tytherleigh et al., 2005). I will now consider the relationship between work and pain, and between work and health more broadly, keeping in mind that work can be both pain-relieving and painful.

2.1 What is work?

In their review Is Work Good for Your Health and Well-being? Waddell and Burton (2006) defined “work” as that which “involves the application of physical or mental effort, skills, knowledge or other personal resources, usually involves commitment over time, and has connotations of effort and a need to labour or exert oneself” (Warr 1987; OECD 2003). Work is not only ‘a job’ or paid employment, but includes unpaid or voluntary work, education and training, family responsibilities and caring” (Waddell and Burton, 2006, p.4). In practice, most of the research to which they referred considered work in terms of employment, defined as “a job [which] typically takes the form of a contractual relationship between the individual worker and an employer over time for financial (and other) remuneration, as a socially acceptable means of earning a living. It involves a specific set of technical and social tasks located within a certain physical and social context (Locke 1969; Warr 1987; Dodu 2005)” (Waddell and Burton, 2006, p.4). Most of the research discussed in this thesis also considers “work” from the perspective of paid employment, as this is the type of activity which has had the most attention paid to it with regards to sick-listing. Paid employment includes very different employment sectors, levels and grades, skilled, semi and unskilled work, as well as self-employment; it is therefore an extremely wide concept.

Different job characteristics have varying effects on workers (Grint, 2005; Waddell and Burton, 2006; Black, 2008). Grint (2005) provided a useful summary of some of the sociological questions underlying the assumption that work has a positive impact on the self. Since the time that “work” has been understood as paid employment, researchers and philosophical writers have reasoned that it is crucial to human satisfaction, but also that its specific form can have negative impacts on the self. Grint (2005) showed that Ruskin, Carlyle, Mill and Marx, amongst others, argued that work should provide the primary foundation for self-development, but that it often failed to do so, and could be oppressive in character.
Christiansen (1999) argued that we need meaningful work, as opposed to simply any work, as work is a main route for the coherent expression of our social identity, which is important for well-being. He posited that if our work is unsatisfying, there may be detrimental consequences for self-construction and presentation. Christiansen takes a social constructionist perspective on what "meaningful" means, and does not operationalize the term. It is nonetheless intuitively plausible that jobs which are satisfying to the worker, however that satisfaction is construed, will assist well-being. There are several theoretical models which attempt to unpack this notion of satisfaction, most notably the demand-control-support model (DCS). This model predicts that the most negative well-being outcomes occur amongst workers in jobs with high demands, low control and low social support (Karasek and Theorell, 1990).

Black (2008) used the DCS model in her *Review of the Health of Britain’s Working Age Population*, in which she concluded that we must improve the nation’s health and get more people back to work as it has such beneficial effects on a wide range of health outcomes. She argued that health and well-being at work are not simply or even largely medical issues, but that the nature and characteristics of the job itself are important, and that satisfaction, reward and control over work must be present. How many jobs fulfil these criteria is unknown, suggesting that some may not be “good” for us. For example, Kivimaki et al. (2000) used a longitudinal cohort design to study factors underlying the effect of organisational downsizing on employees’ health. They found an observed increase in sick leave which was partially explained by concomitant increases in physical demands and job insecurity and a reduction in job control. However, there are criticisms of using the DCS model to consider what kinds of work may be good for us. A review of 20 years’ empirical research concluded that while there is some support for it, the moderating influence of job control and social support is inconsistent (van der Doef et al., 1999). The authors also cautioned that ‘demand’ and ‘control’ are often conceptualised subjectively in the literature, making comparison within and between studies difficult, and people respond differently to the same conditions, even assuming that ‘demand’ and ‘control’ refer to similar phenomena within a study or across studies.

Even in such a brief consideration of what work is, it is clear that there are many different types of job. It is also clear that there can be ‘good’ and ‘bad’ aspects of the same job and that evaluating what constitutes “good” work may be difficult. This needs to be remembered, as although there is high quality evidence, that “good” work is good for us, there are exceptions to this which even the strongest proponents of getting people back to work acknowledge (Black, 2008; Waddell and Burton, 2006). This evidence and these exceptions are discussed below; they are important in the sick-listing process as doctors and patients (and to some degree employers) take account of them when reaching capability decisions. Whether work is seen as positive or negative is a distinction which may have objective features but may also depend on individuals’ interpretation of the meaning of work in their lives.

### 2.2 What is chronic pain?

Pain has been defined by the International Association for the Study of Pain (IASP) as ‘an unpleasant sensory and emotional experience associated with actual and potential tissue damage, or described in terms of such damage’ (IASP, 1986). Chronic pain is defined as ‘pain that persists beyond the normal time of healing’ (IASP, 1986). Chronic pain has also been simply defined as pain that lasts over three months, but due to acute episodes and recurrence, is qualified as intractable pain that does not respond to treatment; leading to associated disability and greatly impacting on individuals’ lives (Waddell, 1998, after Von Korff et al.1992). Von Korff and Miglioretti (2005) also showed that chronic pain is better characterised as a dynamic rather than static state, as its severity often fluctuates over time. Gatchel and Turk (1999) argued that chronic pain
should be viewed as a complex, interactive and psychophysiological set of behaviours. McParland et al. (2011) briefly reviewed definitions of chronic pain and showed it can be conceptualised as ‘a symptom of ‘modern’ life in most advanced economies (Breivik et al., 2006). Discursive accounts of chronic pain vary from the private to the public to the global: it can be considered a personal tragedy (Best, 2007), a national public health epidemic (Reddy, 2006) and a global challenge (Lipman, 2005).” (McParland et al., 2011, p.460). Indeed, Breivik (2002) argued that “although acute pain may reasonably be considered a symptom of disease or injury, chronic and recurrent pain is a specific healthcare problem, a disease in its own right” (p.100) and listed eleven symptoms, physical and psychological, which “add greatly to the burden of the pain patient” (ibid).

These definitions and descriptions of chronic pain are useful when considering if work is good for chronic pain sufferers, as they allow for different ontological conceptions of pain beyond (observable) neurons firing in certain ways. The latter part of the first IASP definition, “or described in terms of such damage” acknowledges that there is no objective measure for pain. Many of the studies discussed in chapter three report patients struggling for validity in the face of a lack of observable pathology; the data analysis reported in chapters five and six also shows patients grappling with language in order to try to communicate the nature and effect of their chronic pain on work and life (Johansson et al., 1999; Merleau-Ponty, 1962). The definitions and descriptions of chronic pain presented here can also potentially be applied to a vast range of symptoms and conditions, including back ache, headaches, and persistent or recurrent pain in almost any part of the body. This can be useful and also makes it very difficult to know exactly how many people suffer from chronic pain conditions. Verhaak et al. (1998) reviewed epidemiological studies of the prevalence of chronic benign pain amongst adults at population and primary care levels. They found that estimates varied between 2% to 40% of the population in different countries, mostly the US, UK, Denmark and Sweden. They argued that this is partly due to a lack of clear definition of chronic pain. To complicate the concept of chronic pain further, it is known that there are high rates of co-morbidity between pain and other disorders such as depression. Breivik et al. (2006) found that 21% of chronic pain patients (in 15 European countries and Israel) were depressed because of their pain.

Recently, the biopsychosocial approach to managing chronic pain has become popular, after its original formulation by Engel (1977) and Waddell’s influential biopsychosocial model of back pain (1998; 2006), showing how patients’ beliefs, coping skills and social network affected their view of their incapacity and interacted with any biological markers. In a review on working with musculoskeletal pain, Buck et al. (2009) summarised biopsychosocial models of chronic pain as placing “psychological factors as a key component of the illness experience, both influencing and being influenced by physical factors and symptoms” (p.7). Their figure, reproduced below with permission, shows how biopsychosocial models have been especially useful at highlighting how patients are part of a multi-level system of interacting parts, including their local workplace, wider organisation, healthcare services, and socio-economic national context. Halligan et al. (2003) argued that the doctor-patient relationship is more fruitful if it is recognised that it involves psychosocial factors as well as disease-based models. Waddell (1998, 2006) showed that sickness absence and incapacity from musculoskeletal disorders could be halved if a biopsychosocial model of rehabilitation, including appropriate sickness certification, was used by all stakeholders. Waddell (1998) argued that as people often react to pain with emotions that lie outside conscious control, doctors must not judge, but try to understand and then provide management strategies for chronic pain. Aylward (2003) contended we have more freedom to choose how to respond to pain than the original biopsychosocial model suggests. Recent work from the biopsychosocial perspective by Main et al., (2010) agreed, and suggested we need to know more about
how GPs’, patients’ and societal beliefs about pain can be elicited, and people need to be empowered to choose more beneficial responses.

May (2005a) discussed how chronic conditions, including lower back pain, can more usefully be conceptualised as illness rather than disease, focusing on the subjective experience of sufferers, and their doctors, “fit[ting] together understanding of the social, and emotional with the biological” (p.15). This is vital if we are to critically engage across the experiential boundaries of both groups. Brievik (2002) and others (e.g. Phillips et al., 2008) raised the profile of chronic pain, to try to persuade policy-makers to improve the enormous burden of chronic pain for the sufferer and for society. May (2005b and 2006a) argued that medicine is run through with power inequalities, and when we approach the question of managing chronic pain, we must consider how we are managing Foucauldian constructions of healthcare. For example, if we create a system in which we try to empower chronic pain patients with Expert Patient Programmes (EPP), we must acknowledge that we are creating a normative model of what is a “good” pain patient. This is currently someone who will listen to a tutor and take an active role in managing their pain by attending a course at which they will “meet and share experiences with others in a
similar situation” and be willing and able to “improve communication skills with your friends, family, work colleagues and not forgetting your health care professionals” (Expert Patients Persistent Pain Programme, 2012). These might be laudable aims but are they achievable for all pain patients? Doctors’ perspectives on the extent to which current pain management services accommodate the needs of patients who cannot achieve the aims of the intervention are explored in chapter seven. Our current healthcare system is not very good at dealing with chronicity without attaching blame to patients who do not get better (Eccleston et al., 1997; May, 2005a and 2005b); again, we could be more aware of this when considering how chronic pain patients are managed. Already, it can be seen that two of the key concepts in this thesis, “work” and “pain”, are very complex entities. They mirror each other in terms of work having objective reality (and pain may have trauma and pathology, although it may not) but also subjectivity i.e. people’s perception of work and of pain and how they behave in response to their working conditions and their pain are shaped by social and psychological factors. When the concepts of “work” and “pain” are applied to the sick-listing consultation, in which there are complex issues around doctor-patient relationships and legitimation of the sick role, and furthermore when workplace and employer-employee relations are factored in, one begins to see how sickness certification is an intricate affair, full of dilemmas and negotiation.

Despite the complexity of what is “pain” and what is “work”, most researchers argue that we must try to reduce the economic and social burden of chronic pain. In Britain during 1994/5, back pain alone accounted for 116 million days of certified incapacity to work (Maniadakis and Gray, 2000). More recently, Phillips (2008) and Collett (2011) highlighted similar costs to the economy and discussed the burden of chronic pain on the individual. Musculoskeletal conditions or disorders have been used as a proxy for chronic pain in many research papers and reviews, because chronic pain can be difficult to define and classify for the purposes of data collection. However, even the widely used category of “Musculoskeletal conditions or disorders” refers to a broad range of medical diagnoses covering common health problems which are often difficult to diagnose due to the nature of subjective, self-reported symptoms, which may or may not correlate with objective symptoms, pathology and impairment. Furthermore, there is no international agreement on exactly what “musculoskeletal conditions” or “disorders” constitute. For example, WHO (2003) used these terms to cover a wide variety of conditions from severe to less severe impairments. In their review of concepts of rehabilitation for common health problems, Waddell and Burton (2004) used “musculoskeletal disorders” to refer to “pain (mostly of musculoskeletal origin); general musculoskeletal symptoms/disorders; upper limb disorders/repetitive strain injury; neck/shoulder/back symptoms; whiplash associated disorders; fibromyalgia; and ‘stress’ with associated musculoskeletal symptoms” (p.46). Waddell and Burton (2004) pointed out that the lack of clear, agreed diagnostic criteria for musculoskeletal disorders remains problematic. In their 2006 review, Waddell and Burton (2006) did not specify exactly what they mean when they use the terminology “musculoskeletal disorders”. Following up all their references, it becomes apparent that this term includes all of the conditions noted above in their (2004) review of rehabilitation for common health problems.

Much literature on musculoskeletal disorders concerns low back pain, but as Waddell and Burton (2006) established, many of the issues raised about back pain are common to other types of musculoskeletal pain, especially neck pain and arm pain. Many UK sickness absence data are based on the category of “musculoskeletal disorders” or “conditions” as opposed to “chronic pain”. Due to this categorisation and due to the similarities between different types of chronic pain and “musculoskeletal disorders” or “conditions” established by Waddell and Burton (2006), “musculoskeletal disorders” or “conditions” are often used as proxies for “chronic pain” in the papers retrieved for this thesis and also therefore in its terminology. However, “musculoskeletal disorders” or “conditions” may not cover other chronic pain conditions such as pelvic pain, abdominal
pain and some rarer chronic pain conditions such as Forestier’s disease (a type of generative arthritis, characterised by unique flowing calcification along the spine) and Chronic Regional Pain Syndrome (CRPS), a severe chronic pain condition characterized by sensory, autonomic, motor, and dystrophic signs and symptoms. Therefore, papers discussing these conditions were also sought, as exemplars of chronic pain not covered by “musculoskeletal disorders” although there was little literature available which discussed such conditions and their impact on work. This in itself necessitates caution when trying to establish if work is good for chronic pain patients. There is, however, a large body of work which considers if work is good for people suffering from musculoskeletal disorders, discussed in section 2.6 below.

2.3 Work as a cause of pain and illness

Black (2008) and Waddell and Burton (2006) state that work must be healthy, safe and offer individuals some control, in order to be beneficial to our health. Black (2008) cites the Health and Safety Executive’s estimate that 25% of sickness absence is due to poor working conditions, adding that different industries create varying risk factors and problems, so it very difficult to offer a single solution. Accidents happen at work and work can lead to harmful exposures e.g. chemicals, asbestos or structural issues such as high levels of noise or heavy lifting leading to bad backs. Injuries of this kind are diminishing in the face of better health and safety at work and the shift from heavy manufacturing and extractive industries (Wainwright and Calnan, 2002). Yet work can also cause psychosocial pressure and exacerbate existing pain and illness. The relationship between the notion of psychological injury being caused or exacerbated by work has a subjective dimension relating to how individuals appraise their situation (Wainwright and Calnan, 2002) yet even proponents of the health benefits of work acknowledge that work can sometimes be a cause of poor health (Black, 2008; Waddell and Burton, 2006).

2.4 The benefits of work for health and pain relief

Waddell and Burton (2006), Black (2008) and Black and Frost (2011) reviewed the research literature on the health benefits of work. Black (2008) used definitions of “health” and “well-being” from Waddell and Burton’s earlier (2006) review. They summarised complex philosophical debates around these two entities, defining “health” as “physical and mental well-being…usually operationalised in terms of the absence of symptoms, illness and morbidity” and “well-being” as “the subjective state of being healthy, happy, contented, comfortable and satisfied with one’s quality of life. It includes physical, material, social, emotional (‘happiness’) and development and activity dimensions” (Waddell and Burton, 2006, p. 4).

Waddell and Burton (2006), Black (2008) and Black and Frost (2011) all concluded that work can confer: economic capital (in the form of wages); social capital (by providing access to social networks, and reinforcing social status through compliance with the work ethic); psychological benefits (by raising self-esteem, confidence and fulfilment); and physical value (as some jobs promote movement and flexibility and some organisations facilitate exercise as a form of attaining well-being). Thus there are biological, psychological and social benefits arising from many types of “good” work, i.e. that which is “safe and accommodating” (Waddell and Burton, 2006, p.ix), leading to better health and well-being.

Black (2008) suggests that the cost of poor health amongst the working age population affects us all. Individuals and their families bear the loss of income, the informal costs of care by family and friends and the emotional costs of worklessness. Employers must bear health-related productivity losses, and costs associated with staff turnover, recruitment and re-training. Black estimates the costs to the NHS to be £5-11 billion per annum, the benefit costs to be £29 billion per annum, with an additional loss of income tax of £28-36 billion per annum, making the total cost for the taxpayer an
estimated £62-76 billion per annum. Black estimates the cost to the economy as a whole to be over £100 billion per annum; more than the Gross Domestic Product (GDP) of Portugal. To this sum must be added the costs of health-related productivity losses that do not lead to absence, estimated by Black at £30 billion per annum. On an economic and social level, therefore, it seems compelling that work is good for us, as most of us need to work for society to function properly.

Waddell and Burton (2006) conducted a review of the evidence around whether work is good for people. They produced strong evidence showing that work is generally good for physical and mental health. They acknowledged that health selection effects may be operating, but their evidence review demonstrated that there is likely to be cause and effect between the variables. Indeed, Waddell and Burton’s earlier work (2004) showed that there is a wealth of high quality evidence that work is good for the physical and mental health of most people. Given the evidence that work appears to be good for us, why are so many people off sick? It could be that doctors and patients do not recognise the health benefits of work and use sickness absence unnecessarily. Certainly the UK government has considered that lack of recognition about work being good for our health and well-being is a major part of the problem of rising sickness certification rates; this is discussed in detail in chapter four. However, the results and discussion chapters suggest other reasons for high sickness absence rates: much depends on doctors’ and patients’ perceptions of an individual patient’s working conditions, rather than work per se, and also some absences from work can be seen to benefit health, improve pain and be better for the business, depending on the context and meaning for the doctor, patient and employer.

2.5 Worklessness, unemployment, health and pain

Worklessness and unemployment are similar but not identical concepts. “Worklessness” is when someone is not engaged in any form of work, including the unemployed and those who are economically inactive (Waddell and Burton, 2006). The latter covers anyone not engaged in the labour market such as carers, homemakers, long-term sick and disabled and retired people (Barham, 2002). “Unemployment” refers to people not employed at a job, who are available for and wanting work (Barham, 2002). For the purposes of this thesis, both worklessness and unemployment are of interest, as research has found that both states can have negative effects on health. Black (2008) showed that worklessness has individual (and even trans-generational) negative effects on physical and mental health, and social integration. Waddell and Burton (2006) did not only find that worklessness is associated with poorer physical and mental health, but that work can reverse the adverse financial, psychological, physical and social effects of unemployment. Their extensive review led them to conclude that this is true for healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. They included some important caveats to this e.g. they demonstrated that an important minority of individuals, possibly 5-10%, may show contrary effects to the general trend that work is good for us. However, this still suggests that work is better than worklessness for 90-95% of people. Australian research with chronic pain patients showed their pain had a large impact on their work performance but also that a significant proportion stated they could and did work effectively whilst in pain (Blyth et al., 2003). This still leaves an important minority of chronic pain patients who reported that they were unable to work effectively whilst suffering from their particular pain condition.

Waddell and Burton (2004) argue that unemployment often leads to physical and mental deterioration (Acheson 1998; Boardman 2001; Thomas et al. 2002; Schneider et al. 2002; Royal College of Psychiatrists 2002; Baker & Jacobs 2003; Schneider et al. 2003). Mclean et al. (2005) carried out an evidence review of what is known about the causal relationships between worklessness and health, and concluded that while there is a relationship, causation remains unproven. They also state that “for certain occupations it
may actually be more advantageous for people’s health to be unemployed as opposed to employed” (p.2). This agrees with Waddell and Burton’s (2006) proviso that approximately 5-10% of people may show contrary effects to the general trend that work is good for us, partly due to the nature of some kinds of work.

In addition to this important caveat, there are points in someone’s working life during which parental leave, part-time working or retirement might benefit health outcomes. For example, a common research finding is that retirement worsens health outcomes for most people but not for all (Behncke, 2012). This thesis and other empirical sources provide evidence of the benefits of part-time work for chronic pain patients, for those who cannot sustain full-time work but are able to continue working some hours, in order to access the fiscal and social benefits of a working life (Healthtalkonline, 2012; Wainwright et al., 2012). Work might generally be better for health than unemployment, but this distinction is not absolute – work is neither always good for a person nor always bad; but depends on the context of someone’s life, their physical, financial and social situation, the meaning they attach to work, and their working environment. It is partly this complexity which makes it challenging for protagonists in the sick-listing and return to work situation to decide how to proceed. I now consider research specific to effects of working for chronic pain patients.

2.6 Work and patients with chronic musculoskeletal pain

Physical risk factors are discussed first, followed by psychological ones. Physical risk factors are complex, as some do not increase the risk of sick leave, some do, and it is often unclear if work causes pain to start or to worsen, or whether this would have happened anyway (Black, 2008). Waddell and Burton (2006) reported that there is a high background prevalence of musculoskeletal conditions, yet most people with disorders such as neck, back, upper limb pain, chronic rheumatic diseases and fibromyalgia do work, even when symptomatic. For example, Fifield et al. (1991) studied sufferers of severe rheumatoid arthritis who remained at work and experienced health benefits from doing so. Waddell and Burton (2006) argued that musculoskeletal conditions may make it harder to cope with the physical demands of work but it does not follow that work is necessarily the cause of the symptoms, nor even that it is causing further harm. However, there is a literature on workplace risk factors for back pain related sickness absence, which shows some evidence that both physical and psychological factors can place workers at risk. Both categories of risk are important for sick-listing decisions as there is evidence that GPs include both in the sickness certification process (Campbell and Ogden, 2006).

Hansson and Jensen (2004) contributed a chapter to the major systematic review on sickness absence by Alexanderson and Norlund (2004) which specifically examined sickness absence due to back and neck disorders. Heavy physical workload and bent or twisted working position were found to have consistent support as a risk factor for sick leave. However, exposure to vibration was not found to significantly increase the risk for either short or long-term sick leave. Hansson and Jensen (2004) cautioned that the generalisability of these findings are limited as most study participants were men in manufacturing industries and stated that we need more research into women, white-collar and public sector workers. In addition, many researchers note that caution is needed when relating back pain to occupation as there is such a high prevalence of back pain in the general population (Waddell and Burton, 2001; Waddell and Aylward, 2005; Werner and Cote, 2009).

Waddell and Burton (2006) accepted that some physical aspects of work are risk factors for developing or maintaining musculoskeletal disorders but provided evidence that effect sizes for such factors alone are small and usually concerned with intense exposures (NIOSH, 1997; Punnett and Wegman, 2004). Waddell and Burton (2006) emphasised the
need to combine occupational and clinical approaches in the secondary prevention of chronic disability.

Assuming that physical risk factors are controlled, Waddell and Burton (2006) showed that early return to work is beneficial for the health and well-being of most workers with musculoskeletal disorders (de Buck et al., 2002; ARMA 2004). Waddell and Burton (2006) noted that there is an assumption with these studies that any significant physical hazards at work are controlled, and elsewhere discussed that questions about the timing of return to work and work adjustments need to be taken into account for individual patients. However, the evidence suggested that early return to work interventions were not associated with any increased risk of more sickness absence or risk of recurrence (Staal et al., 2005; McCluskey et al., 2006).

Waddell and Burton (2006) presented evidence that control (usually reduction) of the physical demands of work can facilitate work retention for people suffering from musculoskeletal disorders. They noted that this conclusion is more applicable to people with a specific musculoskeletal condition than those without. In practice, it may not be possible for employers to reduce physical tasks within a job description. This may reduce GPs’ willingness to certify someone with an unspecified musculoskeletal disorder as fit for work. Indeed, the literature review in chapter three presents some studies which do show that more subjective chronic pain conditions correlate with higher rates of sickness certification (Larsen and Jenkins, 2005; Hussey et al., 2004). In contrast, Watson et al., (1998) found GPs give longer sick notes if a specific cause has been attributed to patients’ back pain, such as “sciatica”, than if there is no such cause. This could be because there is a greater evidence base about recovery times for specific conditions for GPs to use. Not enough is known about possible effects of having a diagnosis versus no diagnosis for the length of sick leave negotiated between chronic pain patients and GPs.

Waddell and Burton (2006) also reported evidence that organisational interventions such as transitional work arrangements (e.g. phased return to work, and modified duties) facilitated return to work for patients with musculoskeletal disorders (Henriksson et al., 2005; Loisel et al., 2005). The sick-listing process allows GPs to make both of these suggestions (i.e. organisational interventions and transitional work arrangements) but employers are not bound to follow their advice; chapters nine and ten discuss empirical work on this issue.

There is some high quality research into psychological risk factors in the workplace for people with chronic musculoskeletal disorders. Werner and Cote (2009) conducted a narrative review, aiming to describe the main determinants of sickness absence for low back pain. One of their four major determinants was the workplace and their review showed several studies which considered that this is the major factor which determines whether someone with low back pain takes sick leave. The impact of reported levels of social support, job control and demands were more important than the impact of physical working conditions (Werner et al. 2007; Hansson and Jensen, 2004). Hansson and Jensen (2004) found that low job satisfaction (lack of social support, low job control and high job demands) increased the risk of short-term and long-term sick leave for people suffering from back and neck pain. Van den Heuvel et al. (2004) analysed questionnaire data from a prospective cohort study, looking at prognostic factors related to recurrent low-back pain and future sickness absence. Low job satisfaction predicted sickness absence due to low back pain. A limitation to this study was that it used a one year time-lag model, which assumed that repeated measurements of an exposure are related to outcome reported at one measurement time later. It is not known if the one year time-lag was appropriate for the variables used to measure low job satisfaction. Also, when discussing the demand-control-support model of job strain, Werner and Cote (2009) noted
that these three components are mediated by workers’ perceptions, and are hence subjective phenomena.

Waddell and Burton (2006) claim that psychosocial factors, both personal and occupational, have powerful effects on musculoskeletal disorders. The personal factors include illness beliefs such as fear avoidance leading to lack of activity and low social support; the occupational factors include job dissatisfaction and job stress as perceived by workers. These factors can prohibit return to work but control of them can also have beneficial outcomes on pain, disability and sick leave (Helliwell and Taylor, 2004). The relationship between psychological injury and chronic pain has a subjective dimension relating to appraisals and meaning. This shows how whether or not work is good for our health and well-being depends upon the complex biopsychosocial web of interactions between: pain sufferers’ biological markers of pain (if any), beliefs about pain and work, social support networks and workplace conditions. Waddell and Burton (2006) conclude that this complexity has to be remembered alongside their main finding that work is generally good for us.

2.7 Work and patients with other types of chronic pain

I have now examined if work provides health benefits for chronic pain patients who are suffering from pain of musculoskeletal types grouped under “musculoskeletal disorders” in the literature: upper limb disorders/repetitive strain injuries, shoulder/back injuries; whiplash associated disorders; fibromyalgia; and ‘stress’ with associated musculoskeletal symptoms. These conditions were considered first as there is a lot of high quality evidence about working whilst suffering from them. I have not yet considered if work is good for chronic pain patients who are suffering from conditions not on this list, for example, people suffering from chronic pelvic pain, chronic abdominal pain and rarer chronic pain conditions such as Forestier’s disease and CRPS. The search strategy of the main literature review in chapter three was set up to include terms likely to retrieve literature about such conditions (see appendix three). It retrieved very little relevant literature concerning if sufferers are helped by being at work, or at least that the benefits of working outweigh the risks. This in itself suggests that we need more evidence before we conclude that work is good for these kinds of chronic pain patients. For example, only one document was found which even mentioned Forestier’s disease and work. Mears (2002) produced a case report of a patient with Forestier’s disease and showed that it severely impeded his ability to work more than a few days a week, as he became fatigued very quickly from back pain. It is impossible to extrapolate general principles to do with the effects of working on sufferers of Forestier’s disease from this case study, which did not discuss characteristics of the patient’s work.

There was little evidence concerning benefits or drawbacks of work for patients suffering from chronic abdominal pain. Nojkov et al. (2010) showed that nurses on rotating shifts (i.e. moving from night to day shifts) have higher rates of Irritable Bowel Syndrome (IBS) than nurses on day shifts. The researchers concluded that participating in rotating shift patterns is associated with the development of IBS and abdominal pain. However, the researchers isolated associations, not causal factors; this study’s conclusion cannot be extrapolated to say that work per se is necessarily harmful or a negative experience even for the nurses on rotating shifts. Beglinger and Gyr (2007) showed that inflammatory bowel diseases, such as Crohn’s disease and ulcerative colitis, are difficult to manage at work due to their unpredictability, but the researchers cautioned that very little long-term data on these issues are available and they did not discuss possible benefits to remaining in work for sufferers of these conditions.

Few studies were found which considered the impact of pelvic pain on working life or whether working could be helpful or unhelpful to pelvic pain sufferers. Fourquet et al. (2010) studied patient-reported outcome data describing the experience of living with
endometriosis, a chronic disease almost exclusively affecting women, with symptoms that include pelvic pain, and found that physical limitations disrupted work. The benefits of being at work were not discussed. Gilmour et al. (2008) interviewed 18 women with endometriosis, and structured their analysis around three main themes, two of which concerned work. These were: disclosure of symptoms at work and the impact of symptoms on work. They found that menstruation problems, bowel and bladder pain and irregularities were embarrassing for women to disclose at work, especially to male bosses, even though these symptoms directly affected women's productivity. Many study participants were also reluctant to disclose their symptoms and diagnosis as they were worried about being pressurised to give up work. One reason given was that they did not wish to be seen as malingerers, as there is usually no objective sign of illness with endometriosis. It is unclear from this study exactly why else the women valued work and if the benefits of working outweighed the physical and psychological difficulties they reported encountering at work.

Only one paper was found which considered the effect of CRPS on working life and it did not report whether continuing at work was helpful. Schwartzman et al. (2009) studied CRPS to expand our current knowledge of the evolution of its symptoms with the duration of disease. They carried out retrospective, cross-sectional analysis using patient questionnaire data. One of the sub-sections was on work status. Schwartzman et al. (2009) reported that "In response to the queries: (1) Did your pain problem cause you to stop working?; and (2) If you stopped working have you been able to return? In 81% of the patients, their pain problem caused them to stop working whereas the remaining 19% continued to work. Of the 81% who stopped working, 27% were able to return to work" (p.278). There is no further detail, so it is not possible to state if patients felt work was an appropriate and wanted goal, although the phrasing of the questions suggests an underlying assumption that it is generally a good aim to try to remain at work.

In summary, there is not enough evidence to state if work is good for patients suffering from Forestier's disease, abdominal pain, pelvic pain and CRPS, although it is possible that some of the positive psychological, fiscal and social benefits of being at work, extensively discussed by Black (2008) apply to some such patients. However, there is much stronger evidence that work is good for patients with musculoskeletal disorders, although Waddell and Burton's (2006) caveats must be taken into account.

2.8 Trends and policy: incapacity benefit reform

Work has been constructed as overwhelmingly positive by current research findings and policy, following strong evidence, but the caveats have not always been taken on board. Similarly, sick leave has been constructed as largely negative, and indeed there is evidence it can facilitate time to disengage from work and for ill health to worsen (Waddell et al., 2003). However, sickness absence can also provide much needed time to recover, which is sometimes diminished or forgotten in research and policy debates (Wade and Halligan, 2007). The abundance of research into positive associations between work and good health must be set in the context of the rapid rise in the number of Incapacity Benefit (IB) recipients and work days lost for sick leave between the late 1970s and the mid-1990s. Since then, numbers have been gradually declining, but Black and Frost (2011) estimate that 140 million working days are currently lost per year in Great Britain. Reducing IB claimants and sickness absence has become a policy issue not simply in order to save money, but also because it is seen as better for the benefit recipient. Waddell et al. (2003) showed that in the acute stages of being off work, under four weeks, workers are likely to return. In the sub-acute stage, four to twelve weeks, the risks of long-term incapacity substantially increase. And once someone reaches the chronic stage, (six months and over), they are at "substantial" risk of long-term incapacity, defined as incapacity of over three months (Waddell et al., 2003, p.29; Waddell and Burton, 2004).
Waddell and Aylward (2005) presented evidence that once someone has claimed IB for a year, they are more likely to die or to retire on IB than to return to work.

Gaining a sick note is a pre-requisite for claiming IB, from the first day of illness if the claimant is entitled to Statutory Sick Pay (SSP) or eighth day if not. Black and Frost (2011) show that sickness certification is the usual entry to IB, so sickness certification has been targeted by the UK government as a key entry point to reduce IB rates. In addition, the Government is also trying to reduce the number of sick notes given to people who are in employment, i.e. these workers do not need sick notes to claim state incapacity benefits, but do need them to present to employers for company or statutory sick pay schemes. Again, this can be seen as a cost-saving measure, and also as a response to evidence that work is good for the health outcomes of most people. A brief summary of IB is now given.

Until October 2008, Incapacity Benefit (IB) was the main National Insurance (NI) benefit in the UK for people of working age who were unable to work because of illness or disability. Most short-term sickness is covered by SSP, a benefit payable by UK employers to employees for up to 28 weeks, enforced in law (Waddell and Burton, 2004). The main focus of IB is on longer-term incapacity once SSP finishes (although short-term lower rate IB provides cover for shorter-term sickness for people who are not covered by SSP). Claimants had to have a sickness certificate from a GP in order to begin to receive IB. To continue to receive IB, other factors were important, such as having to participate in Personal Capability Assessments, or PCAs, with advisors from the Department of Work and Pensions (DWP). IB was replaced by the Employment and Support Allowance (ESA) in October 2008, for new claimants, although existing IB claimants still receive IB. The Labour government had planned to re-assess all IB claimants using ESA’s new Work Capability Assessment (WCA), and put those deemed still incapable of work onto ESA, and those deemed capable of work onto Jobseeker’s Allowance (JSA). The Government stated it would achieve this by 2013 (DWP, 2008a and 2008b) and the coalition government remained committed to this plan. However, it was not until Oct 2010 that the DWP stated that it would begin a small trial to assess the migration of claimants from IB to ESA in October 2010, with national roll out in Feb 2011 and the process completed by March 2014 (DWP, 2010a). The trial began in two UK sites, Burnley and Aberdeen, on 11th Oct 2010. This means that almost 1.5 million IB claimants are expected to go through the conversion process, equating to 10,000 cases a week over three years.

ESA is now the main NI benefit in the UK for people of working age who are newly unable to work due to sickness or disability, with existing claimants remaining on IB, (until they are reassessed, hence will receive ESA or JSA, as explained above). ESA is paid once SSP has finished. ESA is paid at a certain rate for an assessment period of 13 weeks. The Government states that a WCA and medical assessment will probably be carried out, unless it is clear from medical records that the person cannot work. Guidelines attend the decision that someone does not need assessing e.g. if medical staff estimate the person has less than 6 months to live (DWP, 2010b). So the bar to be given ESA without assessment is very high. Once claimants have been assessed, they may be refused ESA and offered JSA (and may appeal). Of those who are offered and accept ESA, the Government then decides whether they join a group requiring return- to-work activities (called the Work Related Activity Group, or WRAG) or whether their health is such that they cannot work (the Support Group). Irrespective of which group someone is in, a higher rate of ESA is paid after 13 weeks, as long as those in the WRAG participate in all work-related activities. As ESA is quite new, there are limited data available on it in relation to sickness certification. Black and Frost (2011) did discuss the effect of ESA on sick notes, stating that that too many people enter the ESA assessment period, as opposed to starting JSA. They suggested this was partly due to “a mis-match between the General Practitioner’s medical certificate…and the all-work-in-depth functional WCA”
The implication is that GPs sick-list too easily, although there is recognition that they need more training and support with occupational health.

Two per cent of the population received IB in 1970; by the time Black published her report into the health of the working age population, using 2006 data, it had risen to 7%, with most of the rise occurring in the mid-1980s (Black, 2008). Inflow to IB has fallen by 40% in the last decade but outflow has also fallen by 35% in the same period, so there has been no large overall fall in numbers and by 2006, there were 60,000 new IB recipients per annum (Black, 2008).

Reasons for being on IB have changed considerably in the past few years. For example, Black (2008) reported that the proportion of IB claimants with mental health disorders rose from 26% in 1996 to 41% in 2006, partly due to a longer than average claim period (there was a large influx of people in 1996 who are still on IB, as outflow for this patient group is small) and a high share of new claimants with mental health disorders. Waddell and Aylward (2005) showed that most of these new claimants with mental health disorders have what are termed minor mental ill health conditions, such as depression and anxiety, rather than there having been a rise in conditions such as schizophrenia. Wainwright (2008) argued that this can be viewed as part of the medicalisation of social problems, rather than objective increases in the ill health of the population. For example, workers respond to stressful working conditions by individualising these circumstances and reporting that they feel depressed, rather than by engaging in trade union activity or mediation to ameliorate workplace difficulties. However, it could also be argued that there was unmet need, which now is being met. The rise in proportions of mental health claimants is also partly due to a fall in the number of new cases related to other conditions, rather than an absolute increase in diagnosis of mental health disorders, which has remained relatively constant at about 200,000 people per annum (Black, 2008).

The number of IB recipients diagnosed with musculoskeletal disorders has reduced since 1996, possibly influenced by improvements in prevention, evidence based treatments especially for back pain, and also for the management of shoulder and neck pain (Black, 2008; Waddell and Burton, 2004). However, musculoskeletal disorders still account for 1 in 8 sick notes, and the average time for such a note is 10 weeks off work, 2 weeks longer than the average for all conditions (Black, 2008). So rates of IB due to musculoskeletal disorders are still high, as are associated economic, personal and social costs. Black and Frost (2011) reported that 41% of all ESA claimants have musculoskeletal problems, constituting the biggest category for being on ESA.

Waddell and Aylward (2005) established that there were approximately 34,200,000 people of working age (16-65) in the UK in 2004. 7.6% of the working age population, or 2.6 million people, were receiving incapacity benefit. Twenty-one per cent of incapacity benefit recipients, or over half a million people, had musculoskeletal disorders. Waddell and Burton (2004) used statistics from the Labour Force Survey (LFS, 2003) to show that 34% of all self-reported long-term disabilities were due to musculoskeletal conditions. They stated that unpublished data from the HSE show that 49% of all self-reported days of sickness absence due to work-related ill health were caused by musculoskeletal conditions.

The large rise in IB recipients in the 1980s is thought to be at least partly due to governmental pressure to remove people from unemployment statistics (Waddell and Aylward, 2005). However, it has been acknowledged that this strategy was a mistake, as about 40% of IB recipients stay on benefits for 52 weeks and these recipients are then likely to continue on long-term incapacity, irrespective of further treatment (Waddell et al. 2002). The optimal window of opportunity for effective clinical and occupational...
management of people on IB is after the first month on benefit (most people go back to work before a month with no interventions) and before the seventh month begins. Therefore, staying on IB for longer than seven months is known to lead to long-term incapacity (Waddell et al., 2002). The rise in IB in the late 1980s may also have been influenced by responses to the pressure of not being able to find a job i.e. it is more legitimate to be seen as “sick” than as unemployed (Barnes et al., 2008). Depending on the exact circumstances of claiming, it is usually slightly more lucrative to claim IB than JSA (see appendix one for current rates of IB, SSA and ESA versus JSA). There is limited evidence that increasing rates of IB are due to malingering; the Government’s own research suggests that only 3.3% of recipients are overpaid IB due to fraud and error, although this represents £210m (DWP, 2010c).

IB rates are problematic. As sickness certification is the gateway to receiving IB, the Government is very keen to reduce what it frames as inappropriate sickness certification on the part of GPs. Sickness certification reduction is also seen as central as it is argued that too easily given sick notes can lead to incapacity, damaging individuals’ health and fiscal outcomes, and costing taxpayers too much money (Niven, 2004; Freud, 2007; Black, 2008). The UK government piloted two interventions designed to engage GPs with the evidence base that work is good for most patients, even if they want sick notes. The first pilot concerned the use of an electronic version of the sick note or Med 3 (the form that was the main means of sickness certification until April 2010). This was tested in a small number of GP practices in Wales to check the feasibility of computerising the certificates (Chang and Irving, 2009). Black (2008) argued that electronic certification would improve communication between stakeholders, which a review suggested would enhance patients’ ability to stay in, or return to, work (Waddell and Burton, 2004). However, the proof of concept evaluation highlighted serious concerns about data confidentiality (Chang and Irving, 2009) and the electronic format of the sick note was superseded by the second pilot. This scheme concerned the new paper “fit note”, designed to focus on what patients can do, rather than what they can’t, and to enable them to gradually increase what they can do. This pilot finished in July 2009 and a formal consultation of stakeholders then took place as part of regulations to introduce changes to the old sick note (DWP, 2009). The draft fit note was very slightly changed due to this consultation and the updated sample fit note (see appendix two) became the final version which went live on 6th April 2010. GPs can still tick the box stating that a patient is not fit for work, but the other option has changed from stating one is “fit for work” to the wording that a patient “may be fit for work taking account of the following advice”. Four options follow: a phased return to work, amended duties, altered hours and workplace adaptations. It is designed to promote the notion that one does not have to be 100% fit in order to work and also to enable successful return to work by providing increased level of detail concerning what can and cannot be done, and by improving communication between stakeholders.

Most papers discussed in this thesis discuss the sick note, as there has been little research so far on the fit note. In mid-2012, it was announced that the fit note had been developed in electronic form, starting national roll out in July 2012 with completion planned by early 2013 (RGCP, 2012). It is exactly the same as a paper note, typed on the doctor’s computer and printed out: it cannot be emailed. The DWP stated that once data security protocols are in place, they will extract anonymous data from these new notes to inform future policy (DWP, 2012a). Very little information was available on the new electronic fit note at the time of writing (August 2012). As well as these three medical notes, the UK government also designed and implemented a training programme for stakeholders on the benefits of work and health, discussed in detail in chapter four.


2.9 Summary: is work good for people in general and for chronic pain patients?

Waddell and Burton (2006) concluded that “sick and disabled people (particularly those with common health problems) should be encouraged and supported to remain in or to re-enter work as soon as possible because it…helps to promote recovery, leads to better health outcomes, minimises the harmful physical, mental and social effects of long-term sickness absence [and] reduces the risk of long-term incapacity” (p.viii). However, the authors cautioned that although the balance of evidence suggests that work is good for health and well-being, three provisos must be considered. These were firstly that we must take into account the nature and quality of work, and secondly that whilst the findings are about average effects, hence apply to most people to some lesser extent, nonetheless a “minority of people may experience contrary health effects from work(lessness)” (Waddell and Burton, 2006, p.ix). Finally, the authors stated that the relationship between work and health must take into account the person’s social context as there are strong links between worklessness, poverty, social disadvantage, social inequalities in health, sickness and incapacity. They reminded us that there are also major geographical dimensions “around deprived areas, high local unemployment rates, limited job availability, and poverty…it is all very well to say that work is good for your health, but that depends on being able to get a job” (Waddell and Burton, 2006, p.35). Since they conducted their influential review, economic conditions have worsened.

The literature review in chapter three and empirical studies in chapters seven and nine show that GPs struggle with these provisos in sickness certification consultations with patients. GPs are subject to cultural and professional norms of sympathy which make them likely to sign someone off if they have any suspicion at all that the individual patient in front of them is in the minority for whom (re)entering work may be detrimental to their health. These doubts are often linked with the poor quality of that patient’s actual or potential job, and with social deprivation and lack of social support (Sawney, 2002). The literature review in chapter three also presents some studies showing that GPs are aware of issues around patients’ quality of work and social context and that these do affect sickness certification consultations (Hiscock and Ritchie, 2001; Campbell and Ogden, 2006).

Conclusion

I have now presented the background to the present debate on work, health and well-being, as this was the setting in which sickness certification was identified as a specific concern. Sickness certification has been targeted for reduction by the Government, as rising incapacity benefit rates, coupled with no increase in objective ill health conditions, have led to the new fit note and training around the notion that work is good for people. However, the policy appears to minimise the complexity of the sick-listing process, for doctors and patients. Work and pain are complex concepts and work can have positive or negative effects on pain and health. Indeed, within the same job, there can be elements of both positivity and negativity which may impact upon health outcomes in different ways. This makes it difficult to judge if work in general or a particular job is likely to have positive or negative effects on an individual patient. In addition, it has been discussed that there are some small but important exceptions to the evidence that safe work is good for us. It has been shown by researchers that work is generally good for most of us, including most chronic pain patients, although policy-makers emphasize this at the expense of the researchers’ own important caveats. These are that the main finding that “work is good for us” is a group finding, which may be inapplicable to an individual patient, that the quality and type of work must be accounted for and that the social context, especially levels of deprivation, must be considered. These caveats are being minimised in the transmission of the message that work is good for us yet affect sickness certification consultations. I have also suggested that work can be good for us, but it depends on the work, on what is the matter with the worker, and crucially, on the way the individual and others in their social network (family, colleagues, employer, doctor, friends) ascribe meaning to both.
The process of sickness certification is central to the construction of both, but this is a highly negotiated and contested process, as explored in the next chapter.
Chapter Three: The Problem of Sickness Certification for Chronic Pain

Introduction
The relationship between work and pain is highly complex and while it may be generally true that pain patients are better off at work than off sick, at an individual level it can be very difficult to judge whether a particular patient can or should work. Responsibility for making this judgement usually falls to the general practitioner, who is charged with being the gatekeeper to sick leave and benefits. This chapter focuses on the research literature relating to sickness certification for patients with chronic pain, describing what happens when a patient with chronic pain requests a sick note and exploring the complex web of factors and negotiated processes that influence sickness certification for chronic pain.

3.1 Search strategy
This search strategy was for the initial literature review of the thesis, designed to discover what was known about sickness certification for chronic pain patients and where the knowledge gaps were. It subsequently informed chapter two (on work and pain), chapter four (on policy) and how I conceptualised its results is part of the justification for choosing the sociological concepts which I then studied in more detail (chapter five). The search strategy aimed to identify and retrieve nationally and internationally published and grey literature and also to retrieve relevant policy documents. Documents were identified by searching and setting up article and citation alerts on electronic bibliographic databases; internet search engines; organisational websites; hand searches of key journals; tracking references from key articles and by contacting experts in the field. The databases searched were: the Cochrane Library (all databases); EthOS (the British Library's e-thesis service); Embase; International Bibliography of Social Sciences (IBSS); OPUS (the University of Bath's electronic research repository); PsycINFO; PubMed; Social Policy and Practice; Web of Knowledge and Zetoc. Searches were initially run in December 2008, and the literature review was updated four times during the PhD before the final version was written in September 2012. Daily alerts from Web of Knowledge and Zetoc and weekly ones from PubMed were used throughout the PhD. The full search strategies are in appendix three. Following the methodology of Waddell and Burton (2006), the search strategy was designed to be inclusive, to retrieve as much material as possible in the first instance. A wide range of material was found, including experimental, clinical and qualitative studies, policy papers, and editorials. Documents were restricted to the English language as there was no budget for translation, and in practice virtually every document was available in English (one was only accessible in Polish, one in German, one in Italian, two in French and four in Norwegian: see inclusion and exclusion flowchart below). No date limits were applied to the searches, although some methods had inherent date limits (e.g. the DWP Research Reports webpages cover 1990-2012 (DWP, 2012b). This literature review was intended to be critical and conceptual in nature, but not systematic, as this was less appropriate for the broad and wide-ranging literature with which the review engaged. Instead of using systematic review methodology, documents were read and critically reviewed, then common core themes and issues were identified as relevant to sickness certification and chronic pain. A dedicated database was constructed, archiving all articles, both included and excluded. Following Waddell et al. (2003), the material retrieved was so varied in nature and quality that it was deemed impossible to apply a standard method of quality rating. Following Waddell and Burton (2006), exclusion was primarily on the basis of irrelevance to the question “what do we know about sickness certification for chronic pain patients and relevant policy?”
The most weight was given to systematic reviews; narrative reviews and editorials were used to develop concepts and find references.

Chapter two justified in detail how many research papers retrieved for this thesis use “musculoskeletal conditions” or “disorders” to refer to many types of chronic pain conditions, including all general musculoskeletal disorders, upper limb pain, RSI, neck, shoulder, arm and back symptoms and fibromyalgia. However, “musculoskeletal disorders” or “conditions” may not cover other chronic pain conditions such as pelvic or abdominal pain, Forestier’s disease or CRPS. The search strategy therefore included “Forestier”, “DISH”, “diffuse idiopathic skeletal hyperostosis”, and “CRPS” as well as “pain”, “chronic pain”, “persist*pain” “to retrieve documents (see appendix three).

It is useful to note at this stage that there are small differences between “sickness certificate”, “sickness certification”, “sick leave” and “sickness absence”. Some studies are not explicit about which they are researching but it is easy to work out, (e.g. see Werner and Cote, 2009). Strictly speaking, “sickness certification” is the process of getting a formal sick note, and to absences formally governed by this note (Waddell and Burton, 2006) and “sickness certificate” means the note itself. “Sick leave” and “sickness absence” refer to not working due to illness, whether the patient has a job or is off sick and on benefits. Waddell and Burton (2004) clarify this can be done by self-report for a week before a note is needed in the UK. This means not all sick leave will be governed by a note but in the literature, absence is often assumed to be based on certification. Mostly, this is a correct assumption, as the literature is usually concerned with absence of more than a week.

As this doctorate is particularly concerned with sickness certification, papers concerning this process are highlighted, but research into sick leave can also be relevant (e.g. when sick note negotiations are influenced by a facet of sick leave, such as GPs’ concerns about sending people back to working conditions which may worsen musculoskeletal disorders (Mowlam et al., 2005; Alexanderson and Norlund, 2004; Hansson and Jensen, 2004)). This is why the search strategy included “sickness
absence” and “sick leave” and why the thesis does consider research which focuses on these things as well as the actual process of sickness certification.

3.2 Issues with data collection and analysis in the literature

There are problems with collecting and analysing data concerning both sick leave and sickness certification. These issues need to be outlined as they are acknowledge in many of the studies retrieved by this literature review, and they can impact upon the robustness and generalisability of some research.

In their systematic review of sickness certification, Alexanderson and Norlund (2004) found that research on sick leave is conducted within different scientific disciplines based on different theories and models. They cautioned that different outcome measures are used, and that terminology is not standardised. These factors made it difficult to compare studies in a robust, confident manner. The authors further noted that variables such as age and gender were often viewed as confounders and there was little attempt to analyse or explain causality. Hensing (2004) studied methodological aspects in sickness-absence research and came to very similar conclusions.

In the UK, Black (2008) also noted discrepancies between different data sources on sick leave. Black stated that the Confederation of British Industry (CBI) calculated that an average of 7 working days per person are lost each year to sickness, whereas the Chartered Institute of Personnel and Development (CIPD) estimated this figure to be 8.4 days and the LFS conducted by the Office of National Statistics (ONS) estimated the figure to be 6 days. Martindale et al. (2009) discussed some of the problems with coding sickness absence data and concluded we should try to improve data collection not simply so the benefit system can be better policed but in order to be able to make better recommendations for improving welfare provision. Three years later, Black and Frost (2011) noted that sickness absence data are still poorly collected, managed and used.

In 2008, Wynne-Jones et al. carried out a systematic review on rates of sickness certification in European primary care. They found 298 citations but only 11 met the inclusion criterion of reporting a measure of sickness certification. They concluded that rates of sickness certification are not routinely recorded in Europe and that the UK does not collect reliable sickness certification data.

Chang and Irving (2009) produced a Government research report on sickness certification and the proposed electronic fit note. They commented that “the current sickness certification scheme is paper-based which has resulted in a lack of robust and accurate information on how many sick notes are issued” (p.15). Gabbay (2009) expressed the hope that the electronic nature of the note would promote more systematic recording of patients’ occupation and work capacity. The authors of both these documents made their comments at a time when the DWP stated that the forthcoming fit note would be electronic, hence improve information gathering. However, the fit note which began on 6th April 2010 is paper based, and there has been no information from the Government on ways to improve data collection on sickness certification with this paper note. The electronic fit note was planned to start roll out July 2012, covering the country by 2013 (RGCP, 2012), and there is an attached objective to improve data collection (DWP, 2012a). At the time of writing, different studies have shown different numbers of sick notes being issued in the UK. Shiels and Gabbay (2007) examined nine GP practices and found that GPs issued an average of six sick notes weekly whereas Sawney (2002) calculated that on average GPs issue 20 sickness certificates each week.

It is not just the number of sickness certificates which is poorly collected; data on duration of sick notes is not routinely collected in the UK. Wynne-Jones et al. (2010a)
suggested this is of significant concern to policy-makers and others trying to reduce rates of sickness absence.

Furthermore, there is evidence to suggest that UK doctors do not record reasons for issued sick notes with consistent quality. Hussey et al. (2004) found some doctors who admitted to making conditions up, as they were so annoyed with the system, and these doctors’ certificates had never been challenged. One said he wrote “neurasthenia” (an old diagnostic term no longer in use in the UK, and this doctor also deliberately made his writing illegible), and another wrote “TALOIA” or “there’s a lot of it about” as his reason for giving a sick note. Hussey et al. (2004) suggested such record-keeping could be viewed as deliberate political protest against doctors’ perceptions of a cumbersome, conflict-ridden system. Certainly, it makes sickness certification research challenging and adds to the concerns of Wynne-Jones et al. (2010a) and Martindale et al. (2009) that sick note data are difficult to use in a meaningful way to plan for better sickness absence policy.

Watson et al. (1998) studied medically certified work loss for back pain sufferers in the working population of Jersey. Jersey is not technically part of the UK but is a separate possession of the Crown, although the definition of “United Kingdom” is confusingly considered to include Jersey (British Nationality Act, 1981). Watson et al. (1998) showed that Jersey has better collection of sickness certification and absence data than the UK. The island records all sickness, incapacity and accident benefits on a database, enabling analysis of the data by individual claimant, GP, ailment code and benefits paid. Ailments are diagnosed on the coding system specifically developed for the purposes of the DSS in Jersey by one of the authors of the study. All medical practitioners use this method of coding reasons for absence from work on medical certificates. Input error rates are monitored internally by auditors and externally by states. These methods of collecting sickness absence data make Jersey an accurate and sophisticated location in which to research sick notes and sick leave. The UK could follow suit although its social security system does differ from Jersey’s. In Jersey, one cannot self-certify for the first 7 days of illness as in the UK. Also, there is no SSP in Jersey, and their Social Security fund pays all compensation for sickness-related work absences, whereas the employer pays up to 28 weeks’ SSP in the UK). Watson et al. (1998) therefore cautioned that extrapolating findings from Jersey to the UK is not straightforward, as there may be factors to do with differences between the two systems that affect how sickness certification is negotiated. However, Watson’s research group also works within mainland UK and their high-quality papers from both the UK and Jersey are used within this thesis as they present valuable findings on sickness certification processes, which they critically and reflexively discuss. Having sounded a note of caution concerning the collection and analysis of sickness certification and sick leave data, I now turn to what is already known about sickness certification for chronic pain patients.

3.3 The magnitude of the problem

It was noted earlier that Black (2008) reported that musculoskeletal disorders account for 1 in 8 or 12.5% of all sick notes. Shiels et al. (2004) calculated that musculoskeletal conditions account for 23% of those with sickness certificates. Wynne-Jones et al. (2010a) wrote a letter to the editor concerning sickness certification for musculoskeletal disorders, based on theirs and others’ previous research. They reported that such disorders are the second most frequent reason for receiving a sick note in primary care (after mental health problems), accounting for approximately 20% of certificates. The percentage difference could be due to differences in methods of data collection. As Wynne-Jones et al. (2010a) highlighted, sickness absence data collection often relies on proxy measures to assess rates of sickness certification, such as work absence records from employers’ databases or self-report, giving potential for error. However, their letter reported rates of musculoskeletal disorders in the UK in 2005, calculated from general practice electronic medical records, completed by participants who had had validated training in coding
conditions. This data collection was taken to be superior to the proxy measures stated above and showed that the extent of the problem of musculoskeletal disorders in primary care is worse than the proxy measures suggest.

In their editor’s letter concerning sickness certification for musculoskeletal conditions, Wynne-Jones et al. (2010a) reported that back pain was the commonest reason for issuing a sick note (132.9 certificates per 1,000 musculoskeletal disorder consultations in men and 88.3 per 1,000 for women) and that a certificate was issued in 1 in 3 back pain consultations. Sciatica was also commonly certified with a rate of 21.3 certificates per 1000 musculoskeletal consultations in men and 20.3 per 1000 in women. Wynne-Jones et al. (2010a) reported that certification rates for inflammatory conditions, including osteoarthritis and lupus, were low. Other conditions that they studied had even lower rates and included lower limb pain, elbow pain, knee pain and general musculoskeletal pain (a full list of the conditions is presented in appendix four). Just as we do not know enough about the prevalence of sick notes for musculoskeletal disorders, due to poor reporting by proxy, we also do not know enough about which conditions are on the notes, for the same reason. It has already been shown that researchers and policy-makers in the field are concerned about this, as it prohibits the growth of our knowledge base, and sensible healthcare planning.

Having considered the magnitude of the problem of sick-listing, and some of the particular issues around data collection, I now turn to the type of problems doctors and patients face in the sick-listing consultation.

3.4 The problem of assessing fitness for work

The nature of the task of sick-listing is perhaps the most obvious problem, as it requires assessment of the patient’s physiological and psychological capabilities, assessment of how this maps onto the demands of their job (if they have one) and also some predictions of the likely health outcomes of staying off work versus returning to the workplace (or getting a job). These tasks may be straightforward e.g. if the patient has a condition with a known recovery timeline, and if it is clear what their work involves. However, in the UK, many sick notes are given for common mental health and musculoskeletal disorders, and these may not entail the certainty of recovery within a specific timeframe (Black, 2008). Also, doctors often report that they do not know enough about patients’ workplaces, and they must then rely on patients’ descriptions. The patient knows more about their job than the doctor; the doctor may be more expert on the pain condition per se than the patient (although in the era of participative, EPP-based medicine, this is not certain, and the patient knows how they feel better than the doctor) and it can be difficult to bring together these two bodies of knowledge. This is partly a technical issue, in terms of mapping the effects of pain onto job demands, and partly a sociological issue to do with competing narratives around who has the power to carry out the assessment of fitness for work.

Werner et al. (2012) conducted a systematic review of physicians’ determinants for sick-listing lower back pain patients. They found eleven papers of enough relevance and quality to include, eight of which concerned GPs. They reported consistent, high quality evidence that doctors’ understanding of patients’ working conditions influenced certification: “The employer’s attitude (‘don’t come back until you’ve completely recovered’), the availability of modified work, and work demands, influenced the assessment of the patients’ working capacity” (p.369). Werner et al. (2012) concluded this important determinant needs further investigation; studies one and two of this thesis researched it. The findings are reported in chapters seven and nine and highlight that the capability decision is often not an objective process but based on non-medical factors. These include patients’ desire or otherwise to work, beliefs about their ill health condition, levels of social support they experience (Werner and Cote, 2009) and how they articulate
all these issues to the doctor and how the doctor perceives them. The capability decision does not adhere to the medical model but requires use of the biopsychosocial paradigm. Some doctors are comfortable with this, and it pervades much of modern general practice, but others find it hard to do, and there is evidence that the social element is not well utilised (Harding et al., 2010). Doctors’ own beliefs about health and illness are also known to affect the assessment of fitness for work (see section 3.5f below). In addition to these issues, demographic factors affect sick-listing, as now discussed.

3.5 Modelling the determinants of sick-listing for chronic pain patients

3.5a Demographics of GP

Wynne-Jones et al. (2010b) surveyed almost one thousand UK GPs and found male GPs issued significantly more notes for all conditions on average than female. However, they reviewed the literature on this, and found inconsistent results. This inconsistency was also present for differences in certification practice by year of qualifying and whether or not GPs took a biomedical approach. The systematic review of certification for lower back pain by Werner et al. (2012) found inconsistent evidence that older doctors or those with more experience issued certificates with greater frequency. Hence it still not known whether and if so how these factors affect sickness certification.

3.5b Gender of GP and patient

Hansson and Jensen (2004) systematically reviewed sickness absence due to back and neck disorders. They found that being female did not significantly increase the risk for either short or long-term sick leave. They cautioned that most study participants were male manufacturing workers, so more women and men in other industries need to be studied.

Shiels and Gabbay (2007) investigated the association of patient, clinician and general practice factors with long-term certified sickness absence (defined as over 28 weeks). They analysed carbon copies of over 3,300 sickness episodes at 9 different GP practices in the UK. They constructed three logistic regression models to estimate independent effects of the patient, GP and the characteristics of the GPs’ practices on the risk of long-term sick leave. They looked at all conditions, then at mild mental health disorders and also at musculoskeletal disorders. For all conditions, they found that the diagnostic reason for the sick note explained over 18% of variance, whilst clinician and general practice effects explained only 3.4% and 2.3% respectively. They found that musculoskeletal claimants were more likely to be male than the whole group of claimants but that there was no significant difference in gender with respect of length of sick leave. This was a strongly designed and executed study which collected data on duration of sick leave, which most studies do not.

In their study of sickness certification for musculoskeletal conditions, Wynne-Jones et al. (2010a) found that one in three consultations resulted in a sickness certificate for men compared to one in four for women i.e. the rate of certification was greater for men than for women. The researchers acknowledged that gender differences may partly be explained by occupation and employment status but noted that previous sickness certification studies (into all conditions, not just musculoskeletal disorders) have shown a GP-patient gender interaction, which may also influence sickness certification for chronic pain patients. We need more research into this. Also, Wynne-Jones et al. (2010a) did not have data on the duration of the sick notes, as such data are not routinely collected in the UK. They suggested that this is a significant concern to policy-makers and others trying to reduce rates of sickness absence.

In a study on the influence of GP and patient gender interaction on the duration of sick notes, Shiels and Gabbay (2006) found that certification of male patients by male GPs was significantly associated with increased prevalence of intermediate (6–28 week)
certified sickness outcomes, compared with females certified by females (OR = 1.38, p = 0.009) for all conditions. The result was demonstrated for only one of the five diagnostic subcategories, minor mental health disorders (the other subcategories were musculoskeletal disorders, injury/poisoning, circulatory disease and respiratory disease). No association was demonstrated between gender interaction and long-term (>28 week) outcome, in the total patient group or within diagnostic subcategories. Therefore, the researchers found no association between gender interaction and certified sickness outcome for musculoskeletal patients. They concluded that GP and patient gender appear to have most impact upon sickness certification in the intermediate period but that we need to know more about the attitudes and content of consultations, in order to shed more light on the gender differences that were found.

3.5c Other patient demographics

Tellnes (1989) found that sickness absence in 40-69 year olds was very significantly higher (p 0.001) than in 16-39 year olds. In their study of sickness certification for musculoskeletal conditions, Wynne-Jones et al. (2010a) found that rates of certification increased with age for all conditions, peaking at 45-49, and declined at retirement. The authors cautioned that they could not consider data on duration of sickness certification, as they are not normally collected in the UK.

Shiels and Gabbay (2004) explored the relationship between patient factors and the transition from short-term to long-term work incapacity, focusing on mild mental health and musculoskeletal problems. They analysed carbonised sick notes from GPs for one year in Merseyside. Their dataset included diagnosis, age, postcode-derived deprivation score, and sickness episode duration. Associations of patient actors with sickness duration outcomes were tested. Shiels and Gabbay (2004) found that musculoskeletal disorders claimants were older than the whole group of claimants, were more likely to claim benefit for over 26 weeks than the whole group of claimants and that there was an age linear relationship with the length of the claim (this was the same as for the whole group of claimants). The authors reported no significant difference between musculoskeletal disorders sufferers in the least-deprived and most-deprived quartiles, in relation to either mean duration of sick leave or the proportions of quartile groups incapacitated for longer than 28 weeks. This study was methodologically robust as the researchers reduced any impact of seasonal epidemics by collecting data for an entire year. However, Shiels and Gabbay (2004) reminded readers that they did not consider data on duration of sickness certification, as they are not normally collected in the UK.

3.5d Structural and social influences on GPs and patients

Arrelov et al. (2005) showed that the sick-listing practice of four categories of Swedish physicians, including GPs, was influenced by local structural factors. After adjustments for the effect of patient age and sex, diagnostic group, county and municipality population size, they found that GPs issued longer certificates for all conditions, including musculoskeletal disorders, if there was a local hospital. They suggested that more research should consider how structural factors influence GPs. However, this is an example of when researchers have tried to model sick-listing by purely quantitative data analysis and the findings are difficult to interpret theoretically. The researchers do not discuss in any detail why the presence or absence of a hospital might affect sick-listing. As Shiels and Gabbay (2006) concluded, we need to study more about the attitudes within and content of consultations. We need to engage qualitatively with doctors’ and patients’ beliefs, in addition to quantitative data collection and analysis. Virtanen et al. (2000)
attempted both, in their study of three Finnish communities with different socio-economic conditions. They studied how the labour market, culture and attitudes interacted with sick-listing, using a mixed methods approach which included documentary analysis, interviews and a questionnaire survey. This study did not detail which types of physicians participated, stating they were simply physicians that employees could visit privately. Considering the Finnish health system, this almost certainly included GPs. Virtanen et al. (2000) showed that communities suffering from low social, economic and cultural capital had higher rates of sick leave (these types of capital were measured by social class, mean income and level of education). The authors showed that physicians sick-listed patients in communities with lower socio-economic status more readily, theorising that this was because the physicians adjusted their certification practices according to the perceived sickness absence practices of the locality. The researchers suggested that workers took into account both their health status and the rules of the locality when deciding whether to take sick leave.

van den Heuvel et al. (2004) found that low co-worker support (OR 4.1, 95% CI 1.6-10.5), and low job satisfaction (OR 2.4, 95% CI 1.3-4.5) were predictors of sickness absence due to low-back pain. This is important, as it is known that GPs' perceptions of their patients' jobs are partly shaped by how the latter describe their working lives (Hiscox and Ritchie, 2001). It is also known that GPs are affected by their perceptions of patients' jobs when considering whether to sick-list and are concerned about sending people back to working conditions which they think may worsen musculoskeletal ill health (Mowlam et al., 2005; Alexanderson and Norlund, 2004; Hansson and Jensen, 2004). However, van den Heuvel et al. (2004) did not show causality, simply predictive value. In a systematic review of sickness absence due to back and neck disorders, Hansson and Jensen (2004) found that deficient social support at work did not significantly increase the risk for short-term and long-term sick leave. This finding is limited by the original studies' propensities towards researching males in the manufacturing industries, and only concerned back and neck pain. It would be useful to know more about low social support at work as a risk factor for other types of chronic pain conditions.

As part of their literature review of factors that may influence sick leave behaviour, Hiscox and Ritchie (2001) found that people are more likely to remain in work if they are concerned about loss of income, including bonuses and overtime, or the state of the labour market. Coole et al. (2010b) reported that patients gave financial worries as a major reason for resisting sickness certification when it was being offered by their GPs. However, Werner and Cote’s (2009) review concluded that studies on the association between unemployment rate and sickness absence show conflicting results. Virtanen et al. (2000) suggested that this may be due to individuals’ perceptions of interactions between different levels of both economic support and societal acceptance of being sick-listed. Virtanen et al. (2000) showed that these perceptions appeared to be strongly mediated by sickness absence views and practices within an individual’s work peers.

Andersson et al. (2011) showed an individual’s risk of being sick-listed (for any condition, including pain) was higher if they had family members recently sick-listed. They suggested this may be due to an effect of social norms around sick-listing in families.

**3.5e Chronic pain patients’ beliefs**

What chronic pain patients think about their capacity and incapacity has been shown to affect sickness certification. A recent review of the importance of back pain beliefs for satisfactory recovery from back pain showed that there are relationships between patients’ treatment preferences and expectations and their clinical and workplace outcomes (Main et al., 2010). Morris and Watson (2011) investigated patient and GP factors which determine sickness certification, by analysing questionnaire data. Morris and Watson (2011) found no difference between sick-listed and non-sick-listed patients for age, back
beliefs (beliefs about potentially negative outcomes of suffering an episode of low back pain), anxiety, depression or fear-avoidance beliefs about physical activity. However, those sick-listed showed greater showed greater pain intensity (p=0.009), perceived disability (p=0.040), and fear-avoidance beliefs about work (p=0.000) (as reported to four decimal places in the paper, p.278 and p.281). Patients’ fears were work-specific and not to do with physical activity in general. Morris and Watson (2011) suggested that these fears could be addressed in pain clinics, interaction with health care practitioners and even in the workplace. The researchers suggested that practitioners need more training on how to elicit patients’ beliefs (we know patients may not have opportunities to express them, Barry et al., 2003). Main et al.’s (2010) review concluded that it is really important to try to elicit and take into account patients’ beliefs, and we need to know much more about the identification, management and modification of these. Morris and Watson (2011) and Jellema et al. (2005) also showed that the effect of training on practitioner behaviour is variable.

Morris and Watson’s (2011) regression model showed that combining GP and patient factors gave the most powerful predictive value to whether or not a sick note would be given. The researchers suggested that some factors are amenable to intervention, such as patients’ fear-avoidance beliefs and GPs’ taking a biopsychosocial orientation. I now turn to how GPs’ beliefs about pain, work and health affect sickness certification.

3.5f GPs’ beliefs

GP beliefs can be conceptualised as part of GP habitus, suggesting that GPs will be influenced by professional discourse but will also have agency over their beliefs. It is unclear exactly how GPs’ sickness certification practices for chronic pain are mediated by their beliefs about pain. However, there is some evidence, discussed below, that beliefs are important for how GPs conduct themselves in this area. These include fear avoidance beliefs, their own work ethic and experiences of being a patient, beliefs about how to predict recovery from back pain and finally whether or not they used the biopsychosocial model.

Several studies suggest that GPs’ own fear-avoidance beliefs about low back pain (e.g. how far they believed sufferers should avoid movement for fear of exacerbating pain) were negatively influencing their ability to follow back pain guidelines that activity is better than rest. These studies suggest that doctors with strong fear-avoidance beliefs hinder patients’ recovery and ability to stay in, or return to, work. For example, the systematic review by Werner et al. (2012) found strong evidence that doctors’ high levels of personal fear avoidance beliefs about low back pain correlated with issuing longer certificates. Linton et al. (2002) provided evidence that healthcare practitioners (half of whom were GPs) who held high fear avoidance beliefs for low back pain, were twice as likely to believe that sick notes are a good treatment for back pain, compared to those with low levels of such beliefs. Coudeyre et al. (2006) demonstrated that French GPs’ scores on the Fear-Avoidance Beliefs Questionnaire (FABQ) about low back pain were associated with prescribing sick leave to patients with low back pain.

In contrast to these studies, Watson et al. (2008) showed that GPs’ certification for NSLBP (non-specific lower back pain) was predicted by their sickness certification behaviour in general and not by scores on the PABS (Pain Attitudes and Beliefs Scale). Watson et al. (2008) therefore concluded that GPs’ sickness absence certification for low back pain is not directly associated with beliefs about back pain. Watson et al. (2008) noted that their study may have limitations, as they addressed only the number of sick notes given and not their duration. They also studied a population in Jersey, which may be unrepresentative of patient populations elsewhere. They maintained that the process of sickness certification is complex, and that “it is rather too simple to believe that the healthcare professional’s attitude alone is the main determinant of the consultation.”
Indeed, the researchers cited other studies showing that in sickness certification consultations in general (not just for chronic pain conditions), doctors bring to bear a wide range of knowledge about individual patients’ jobs and personal and social circumstances. However, even if the healthcare professional’s attitude is not the sole determinant of a sickness certification consultation, the systematic review by Werner et al. (2012) suggested it is one of the two main determinants of factors internal to the doctor (the other was their distress at the complexity of sick-listing).

GPs’ understanding of patients’ working opportunities, their own work ethic and their personal experiences of being a patient also affect sick-listing negotiations. Hiscock and Ritchie (2001) conducted a large qualitative study for the UK government on the role of GPs in sickness certification. They found that GPs had strongly held beliefs around work and health and that these beliefs affected their sickness certification behaviour. GPs said that “job prospects, opportunities for employment rehabilitation, and patients’ motivation to work” were the main factors which affected whether or not they sick-listed patients (p.17). GPs said that when negotiating sick leave, they took into account their own work ethic and feelings about work and health (as did GPs in a later study by Cohen et al., 2009, see below) as well as their patients’ social and financial situations. Some GPs thought that work helps to keep people psychologically well because of the sense of esteem it can bring, and placed return to work as a high priority in their management of patients. Other GPs identified more of the problems work can bring and were more inclined to provide a “way out” from a difficult work situation for their patient (p.49). It is important to note, however, that whilst GPs deem the quality of patients’ job opportunities important for the sick-listing decision, there is evidence that doctors do not discriminate against patients who need a sick note for benefit purposes as opposed to work, by treating these situations more lightly. Mowlam et al. (2005) carried out in-depth interviews with GPs to explore their approaches to managing sickness absence and return to work support. Mowlam et al. (2005) reported that doctors felt very strongly that equality of treatment for all patients was very important, and that providing treatment on the basis of working status would be wrong. Mowlam et al. (2005) noted that whilst “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, …in general, work issues appeared not in themselves to influence clinical treatment decisions” (p.2).

GPs’ experiences of being a patient also had a direct effect on how they viewed people coming to surgery with subjective health complaints in work by Nilsen et al. (2011). GPs who had suffered similarly subjective complaints were more empathetic and sympathetic to their patients, hence more likely to sick-list them.

Main et al. (2010) carried out an evidence-based review of healthcarers’ and patients’ pain beliefs and their influence on pain perception and response to treatment. Main et al. (2010) did not explicitly consider sickness certification but did discuss studies which have shown that GPs’ views affect the kinds of treatment and advice that they offer to pain patients, including abstinence from or the continuation of work. For example, Main et al. (2010) cited Perrot et al. (2009) who surveyed patients’ and physicians’ expectations concerning recovery from back pain. Of the physicians surveyed by Perrot et al. (2009), 82.4% were GPs and 17.6% were rheumatologists, so their study may be considered as representative of French GPs’ views, and Niven (2004) showed that the French system is similar enough to ours to allow for sensible comparisons between the two countries. Perrot et al. (2009) found that physicians considered a large range of patient variables to be predictive of recovery, including previous sick leave, marital status, working status, age, obesity, professional status and analgesic use. However, patients did not consider these variables to predict recovery, seeing themselves as having an individual narrative more likely to be predictive, leading to areas of conflict in consultations. Main et al. (2010) concluded that their review showed tools to measure healthcare professionals’ attitudes
and beliefs are in their infancy, but that it is important to develop them, as beliefs do affect consultations, treatment and outcomes.

Finally in this section, it is important to examine the wider perspective doctors take, under which they structure many of their beliefs. Doctors who take a biomedical view have been shown to struggle with sickness certification and write more sick notes, as they lack a functional model of back pain rehabilitation and showed narrow views of preventing disability (Morris and Watson, 2011). GPs with this biomedical view appear to err on the side of caution and sign someone off when biomedical recovery timelines are inappropriate for an undiagnosed chronic pain condition, or when biomedical markers of pain do not match patients; accounts or are even absent. Taking a biopsychosocial approach to sickness certification was shown to reduce the number of sick notes given in the investigation of determinants of sickness absence for lower back pain by Morris and Watson (2011). The researchers therefore suggested that it would be advantageous to encourage biopsychosocial orientations in GPs, although they cautioned that not enough is known about the influence of training on GPs’ behaviour. Also, their study examined what GPs say that they would do rather than actual consultation data; more research on this area within clinical practice is needed. However, an earlier paper by Waddell (2006) also argued that sickness absence and incapacity from musculoskeletal disorders could be reduced by 33-50% if a biopsychosocial model of rehabilitation, including appropriate sickness certification, was used by all stakeholders. Waddell (2006) and Buck et al. (2009) maintained that it is only by addressing all the physical, psychological and social factors involved in illness and disability, that we will be able to improve sickness absence rates and health and work outcome from sufferers of musculoskeletal disorders. Foster et al. (2003) argued that a biomedical approach to treating chronic musculoskeletal pain is inadequate. However, a systematic review by Parsons et al. (2007) found that healthcare professionals still felt more comfortable using the biomedical model to manage chronic musculoskeletal pain. e.g. they often had expectations of making a diagnosis. Parsons et al. (2007) discussed how doctors medicalised psychosocial problems, partly as they were comfortable within this discourse and also as they believed patients wanted their pain thus conceptualised. Parsons et al. (2007) reported that patients often discussed their pain with their doctors within a biomedical framework, even if they thought psychological factors contributed, as this is what they thought their doctors wanted.

These kinds of complex issues suggest that it can be difficult to understand how to interrelate elements of the biopsychosocial model, and to apply it (Ghaemi, 2009), but it appears likely that training doctors how to incorporate it into general practice without feeling that their biomedical expertise is being diminished would result in less sick-listing. The research into sick-listing within these two competing discourses suggests the biopsychosocial’s fewer sick notes is a better paradigm as this prevents needless disability (Morris and Watson, 2011). This fits well with the new policy objectives around sick-listing, discussed in chapter four. However, the discussion showed doctors need to believe that available work must be safe and accommodating, before they will send more patients back to their jobs.

To summarise so far, there are clearly quantifiable factors affecting sick-listing, such as age and gender of both doctor and patient, and stakeholders’ beliefs about chronic pain, work and illness. Sickness certification is also affected by how protagonists construct the meaning of macro-level structures around them. Patients consider what their job means to them, how much they value the support or censure of peers, how much they want and need financial resources. Doctors consider whether they think patients’ jobs will help or hinder health outcomes, as well as responding to community values about sick leave. Only so much can be understood by looking at what doctors and patients bring to a consultation; we also need to look at the process of negotiation that occurs during the consultation. Sickness certification is also affected by protagonists’ construction of the
meaning of micro-interactions between each other and it is to this complex issue that I now turn.

3.6 The doctor-patient relationship and the negotiation of meaning: the dynamics of the consultation

The sickness certification literature shows that doctors often want to preserve good relationships with their patients and are reluctant to enter into conflict about the capability decision, particularly when the consultation concerns medically unexplained, and therefore contestable, symptoms. Chronic pain is a good exemplar of this kind of complaint where there may be no evidence of pathology or the pathology that is found may not fit with the patient’s account. Assessing the physiological and psychological capability of the patient can thus be challenging. Sickness certification is also more challenging because the consultation concerns the workplace (at least for patients with jobs, as opposed to those who need a sick note for incapacity benefit) which is outside the direct experience of the general practice consultation and must be described by the patient and supplemented by the doctor’s knowledge of occupational health and of the patient. The following section examines what we know about these complex issues, starting with sickness certification consultations in general, and then focussing on issues specific to consultations with chronic pain patients. Some of the general sick-listing research findings which are important for chronic pain are discussed, as it is known that musculoskeletal disorders are the second most likely reason doctors give sick notes (Black, 2008). Because of this, most of the sick-listing research which considers all conditions includes information about chronic pain.

3.6a Conflict

Conflict is a key theme which emerges from analysis of the sickness certification literature. Many studies and reviews report that most doctors are unwilling to enter into conflict with patients over sick-listing (Hussey et al., 2004; Nilsen et al., 2011; Wynne-Jones et al., 2010c; Waddell and Aylward, 2005; Cohen, 2008). Conflict can arise when the patient requests a note and doctor does not want to give one, or the patient wants to remain at work and the doctor does not think it is advisable. Many studies report the former situation is by far the most common. For example, Wynne-Jones et al. (2010c) reviewed studies examining GPs’ attitudes to sickness certification for all conditions. They found that conflict between GPs and patients was one of the major themes. It is striking that GPs reported sick notes caused them problems on a weekly basis. GPs found handing patient conflict, decisions over prolonging sick notes, assessing workability, and deciding the most appropriate duration of sick notes “fairly or very problematic” (p.71). In their review, Wynne-Jones et al. (2010c) found that GPs felt in conflict between other stakeholders such as employers and secondary healthcare professionals, as GPs felt their main role as doctor was in tension with what these other protagonists wanted from them. For example, GPs were worried about breaching doctor-patient confidentiality when considering the narrow distinction between providing information about a patient’s health and functional ability. This was one of the biggest concerns given in GP interviews about the possibility of making the fit note electronic (Chang and Irving, 2009).

Cohen et al. (2009) carried out structured discussion groups with GPs in South Wales, aiming to explore GP and patient interactions around the fitness for work consultations for all conditions. Cohen et al. (2009) reported that lack of knowledge (of compensation and benefit systems) made GPs feel defensive in sick note negotiations, and that they recognised this made it harder to practise “good medicine” (p.349), as it affected how they spoke to patients. Cohen et al. (2009) found that GPs were particularly concerned with role legitimacy and fears that within the current system, their job is not clearly defined. They were frustrated by trying to manage sickness certification within the wider political context, which they saw as shifting too quickly without due regard for general practice systems. GPs felt that negotiating welfare changes was not their job and not what they
trained for. GPs also lacked confidence in negotiating with patients due to uncertainty about what patients wanted, and felt manipulated when patients waited until the end of a consultation to ask for a sick note, as the process then became a game of wits. Lack of time in a consultation affected GPs’ confidence in their ability to negotiate sick notes, and this was exacerbated when patients asked for a note at the end of the allotted consultation time.

The innovative study by Cohen et al. (2009) used behaviour change methods to engage GPs in considering how (and why) they behave in consultations rather than simply considering process issues. The study employed motivational interviewing and action research methodologies to encourage participants’ enhanced engagement, and GPs moved from initial resistance to talking about change to actively discussing how consultations could be improved. GPs felt that they often assume that patients come wanting a sick note, and that it would be better if they adopted a more open attitude at the beginning of the consultation. It is interesting that GPs reported this despite also complaining that they felt manipulated when patients asked for a sick note at the end of the consultation – it is as if GPs subconsciously expected the issue to be raised but still resisted this on the surface, perhaps because it preserved their sense of being in control.

Seven GPs participated in Cohen et al.’s (2009) study which comprised two sessions, each lasting three hours. Although rich data were generated, the small geographically specific sample, limits the generalizability of the findings, as the researchers acknowledged. Also, the stated aim of the study was to explore GP and patient interactions around the fitness for work consultations, but this was done solely from the viewpoint of GPs and it would be useful to complement this study with in-depth consideration of patients’ views. Coole et al. (2010b) and Wrapson and Mewse (2011a) are two of the very few studies that do this, both discussed below; the first empirical study for this thesis, continues to unpack the complexity of both GP and patient views of the sickness certification process.

Many studies have found that GPs report a sense of conflict between their duty to do their best for an individual patient and their role as gatekeeper to sickness benefits. For example, Hussey et al. (2004) carried out focus groups with Scottish GPs from a range of different practice sizes and types, about their views on sickness certification for all conditions. They found GPs experienced a lot of conflict, not only between themselves and their patients, but also between their ideal of patient-centred practice and the policy imperative to reduce rates of sickness certification. They felt they were being asked to endanger supportive doctor-patient relationships for the sake of reducing the benefits bill.

GPs also have strong views on the sick role’s legitimisation of patients. The sick role is discussed in detail in chapter five but appears in some of the sick-listing literature as a reason for why doctors and patients struggle over certification. Briefly, according to Parsons’ (1951) formulation of the sick-role, being sick-listed by the doctor allows the patient to feel validated as unwell and to temporarily withdraw from duties: in return they must seek to get well. The doctor has a duty to give the best care possible. Wahlstrom and Alexanderson (2004) contributed a chapter to a large systematic review of sickness certification, concentrating on physicians’ sick-listing practices. They found that GPs were concerned about legitimising the sick role for back pain patients, in that this could exacerbate any psychological distress patients were experiencing by reducing physical, society and work-based functioning. This shows the complexity of doctors’ feelings about the sick role; they understood why patients wanted, and often needed, to enter it, but were also worried about how they would help patients to leave it again, especially patients with chronic, fluctuating conditions.
Hiscock and Ritchie (2001)’s review of GP and patient views on sickness certification found that issuing a sick note made patients feel that their illness was legitimate, and reduced their concerns about being perceived as malingering. Hiscock and Ritchie (2001) argued that doctors legitimised their patients’ sick role too easily but that this was partly because sometimes GPs did not know how else to help their patients and honestly believed that giving a sick note was a positive intervention which they could at least offer, even if they could not effectively treat the patient’s ill health condition. The authors also noted that GPs were very concerned to preserve trust in doctor-patient relationships and felt that this would be eroded if a sick note was not forthcoming. Hiscock and Ritchie (2001) argued that this often rendered patients passive and dependent. Cohen (2008) reported similar findings.

Werner and Cote (2009) conducted a non-systematic review, aiming to describe the main determinants of sickness absence for low back pain. They structured the determinants found into four main levels: the sick-listed worker, the sick-listing doctor, the workplace and the cultural and economic conditions of society. They concluded that determinants of sickness absence for low back pain are complex, mainly non-medical and warrant further study. Their findings about the sick-listing doctor highlight the conflict doctors feel between preserving good doctor-patient relationships by giving sick notes when this may not be in the patient’s best interest or accord with the doctor’s clinical judgement, but it is what the patient wants. Werner and Cote reported a Norwegian study which showed that patients who asked for a sick note got them 95% of the time, even if a sick note was judged inappropriate by the GP (Larsen et al., 1994). Another Swedish study showed that even when doctors did not recommend sick-listing, a sick note was given in 87% of cases (Englund and Svardsudd, 2000). Verbeek et al. (2004) carried out a systematic review of studies on patient expectations of treatment for back pain. They found that patients want a clear diagnosis of their pain, a physical examination, pain relief, instructions, and sickness certification. It is difficult for some GPs to refuse a sick note in the face of such clear expectations. Mowlam et al. (2005) found that GPs would discuss return to work to some degree, but would not proceed further with persuasion if they met resistance. Werner et al.’s (2012) systematic review also found moderately high quality evidence that doctors felt patients’ expectations were a dominant part of their reason to sick-list (they cited Chew-Graham and May, 1999 and two other good qualitative studies). These doctors also felt that their ability to persuade or help was limited, whereas the Government is clearly positioning GPs as pivotal in its battle to reduce sickness certification (DWP 2010d and e). This discrepancy almost certainly needs addressing if the Government wishes to change GP behaviour.

Money et al. (2010) examined GPs’ perspectives on who initiated sick note requests. They found that in 60% of all sickness certification consultations, patients initiated the request compared to 37% suggested by GPs (47% of all the consultations concerned mental health conditions and 37% musculoskeletal disorders). Money et al. (2010) reported that fewer certificates were requested by musculoskeletal patients than patients suffering from mental health conditions but did not report these percentages. The authors implied that it was still the case when analysing data from musculoskeletal patients’ consultations that patients initiated more sick notes than their GPs. Some of the doctors in this study felt in conflict with patients and would give a sick note if it was wanted, even if they felt it was not in the patient’s interests. Other doctors felt comfortable challenging patients’ views on work and health, so although it could be argued they were still in some conflict with patients initially, this did not appear to worry them (in contrast to doctors studied by Larsen and Jenkins, 2005) and indeed they used this conflict as the spur to help patients out of the sick role, writing fewer sick notes. The doctors in this study were all trained in OH; this training appeared to help some of them deal with conflict but not others.
Some studies were found which did not report that GPs felt conflict over sickness certification, rather that they were satisfied that they were in charge of the capability decision (although they wanted more training on making it). For example, Wynne-Jones et al. (2010b) conducted a cross-sectional postal survey of UK GPs’ views on sickness certification for all conditions. Over seventy per cent of their 1,000 respondents reported that it is patients who initiate certification discussions but two-thirds of GPs said this did not affect their decision to issue or not. This finding mirrors a result on decision-making reported by Campbell and Ogden (2006). It does not suggest a negotiated model of decision-making although overt conflict appears absent.

In contrast to the studies above which showed GPs’ perspective that patients actively pursue sick notes, Coole et al. (2010b) found that lower back pain patients felt frustrated by GPs who offered or were perceived to almost force sick notes on them when this was not what the patients wanted (the only reason given for not wanting a sick note were financial concerns about being off work). Patients reported feeling that they had to comply with GPs’ wishes, although one actively managed his GP by requesting that instead of being signed off, the GP recommended he was fit for work, albeit with lighter duties. This was one of the few studies which considered sickness certification for chronic pain patients from the patient’s viewpoint.

A few studies were found which highlighted interactions that were less combative in nature. Wrapson and Mewse (2011a) showed that the sick-listing consultation does not have to be imbued with conflict, but can include negotiation and power sharing. However, these elements brought their own problems, which pain exacerbated. Wrapson and Mewse (2011a) used grounded theory principles to analyse the interview dialogue of patients suffering from low back pain lasting over one month who were currently or had recently been off work. Patients were asked to discuss recent certification consultations and the authors categorised responses into four typologies according to who had power in the consultation. These were: “process” (the GP makes the capability decision alone, which was contemporaneously accepted and later questioned by patients); “cued” (the patient takes control in directing the doctor); “consultative” (shared decision-making occurred) and finally “laissez-faire” (the doctor has power but gives it to the patient by trusting their account and allowing it to prevail). Therefore, all but “process” allowed the patient influence in the decision. Wrapson and Mewse (2011a) found that about half of the consultations were “process” and half were composed of all the other three categories. Therefore, patients had considerable input into the sick-listing process, and within the “process” category, patients did not report any more dissatisfaction or satisfaction with the consultation than for the other categories. This appeared to be because “when GPs are in any doubt as to workability, it seems they may adopt a “compassionate approach” and write a medical certificate if this seems to be the patient’s expectation” (p.206). The authors discussed how GPs allowed patients much power in sick-listing, partly due to preserving doctor-patient relationships, but also as doctors were responding to the model of shared decision-making which is now seen as appropriate to many general practice consultations. The researchers suggested that it would be useful to know if shared decision-making impacts on the return to work process. They caution that whilst it is important to allow patients involvement in medical decision making, we know there is not always a correlation between pain and the ability to perform physical tasks (Rainville et al., 1992). It is therefore important that doctors do not “relinquish total control” (ibid, p.208) as they have more medical expertise than the patient. This is a difficult issue, as the doctor should know much more medical knowledge and be able to make some predictions about rehabilitation outcomes but this is very difficult when they do not quite know how the patient feels or exactly what their workplace is like. Recent policy documents and aid memoires for GPs on sickness certification do suggest that negotiations could be a fruitful part of the sick-listing process but the studies by Campbell and Ogden (2006) and Wynne-Jones et al. (2010b) suggests this does not happen much in practice. The research by
Wrapson and Mewse (2011a) also shows how the idea of shared decision making may be useful in principle, but that there are other factors to consider when putting this into practice.

### 3.6b The contestability of pain

When the literature on sickness certification specifically for chronic pain was reviewed, the key emergent theme was that the often subjective nature of pain exacerbated the issue of conflict. This included conflict between doctors and patients, as well as doctors and policy-makers, and these modes of conflict were further complicated by tensions between the biomedical and biopsychosocial strands of general practice discourse.

An important area of conflict was between different explanatory models of pain. Chew-Graham and May (1999) and Hussey et al. (2004) both reported that GPs found it hard to challenge patients’ explanations for their pain condition. Chew-Graham and May (1999) studied chronic lower back pain, for which there was not always any observable pathology. Their qualitative study interviewed twenty GPs, to explore their views and understanding of the management of this condition. The authors argued that patients wanted a physical cause to be found for their pain, so that they did not feel delegitimised, as they considered themselves subject to a moral hierarchy with physical causes of illness behaviour above psychological (Wainwright et al. 2006). However, the doctors’ model of chronic lower back pain stressed psychological factors, giving rise to conflict in GP-patient negotiations around sickness certification. Doctors in this study did not think that their patients viewed physical back pain as stigmatising (and did not perceive it thus themselves). However, these doctors suggested that the depression that they thought many back pain patients had was viewed as stigmatising (by patients, not by the GPs) and that there was work to be done to de-stigmatise how pain patients felt about that part of their ill health. Watson et al. (2008) discussed this work by Chew-Graham and May (1999) and suggested that GPs with a psychosocial orientation towards dealing with their chronic pain patients focussed on factors such as GP-patient relationships and colluded in their patients’ biomedical views of the problem. Watson et al. (2008) did not develop arguments concerning the effect of this, but their choice of the verb “collude” implies they thought it problematic. If pain patients do feel stigmatised by comorbid psychological distress, then more active management of such stigma during sickness certification could be a useful tool, as it is known that mental ill health can improve by (re)engagement with good working opportunities (Waddell and Burton, 2006; Black, 2008).

It can be difficult for doctors to challenge patients’ perceptions of pain and work within the constraints of the consultation. There are many measures of pain, including quantitative sensory testing; self-report measures, such as the McGill Pain Questionnaire (MPQ, Melzack, 1975); physiological measures such as heart rate and imaging techniques; and cognitive and emotional measures such as appraisal processes. The GP may refer the patient to be assessed using other pain measures (e.g. to a psychologist for the MPQ) but resource constraints may lead the GP to use behavioural measures such as the patients’ posture, guarding behaviour, rubbing and facial expressions, as initial pain measures (Prkachin et al., 2007). These may be difficult to interpret and partly depend on the skill of the practitioner. Merleau-Ponty (1962) argued that pain cannot be retained in consciousness, making it hard for some patients to communicate the extent of their problems to the GP if their chronic pain condition fluctuates and happens to be waning at the time of the consultation.

Waddell and Aylward (2005) and Cohen (2008) reviewed the literature and concluded that obtaining a sick note is largely dependent on patients’ own perceptions of their situation. These researchers argued that sometimes it is appropriate for GPs to challenge patients, if they think patients are locked into unhelpful ways of thinking. For example, if a back pain patient with no clinical red flags attached was still very cautious about moving
around, exercising or returning to work, the GP may be convinced from examination and the consultation that these things will help the patient. However, the doctor is still left with the problem of how to negotiate with or persuade the patient towards this view, if the patient disagrees. For example, Chew and May (1997) found that sufferers of chronic lower back pain without definable cause used their doctors as a resource to legitimate their social and economic inactivity. This accorded patients a lot of power over doctors as GPs were unable to challenge patients’ accounts of ill health without damaging the doctor-patient relationship.

The contestability of chronic pain also made doctors’ experiences of the whole system of sickness certification more difficult than for objectively defined conditions. Until the fit note, sick-listing was an either-or proposition and yet such polarisation is challenging to apply to chronic pain. The fit note has not really changed this, as discussed in the results chapters. Larsen and Jenkins (2005) evaluated an e-learning module on sickness certification for UK doctors. They found that medically unexplained symptoms, including pain, accounted for a large proportion of a UK GP’s workload and that GPs had more difficulty in sickness consultations with these conditions than with medically explained disorders. They noted that GPs frequently worried that their assessment of patients’ ability to return to work remained subjective. Such subjectivity does not fit the sick-listing system nor the still dominant biomedical demands of general practice. The doctors in the study by Hussey et al. (2004) were not reported as being worried but as angry that the sick-listing system discourages subjectivity and simply does not fit complex and chronic ill health conditions. They particularly noted that the system requires them to make decisions about whether or not to sick-list someone without objective clinical findings but that this very difficult. This concords with findings by Haaland Haldorsen et al. (1996) who studied the challenges of sickness certification for musculoskeletal disorders in Norway, using a postal survey based on case histories. Indeed, Haaland Haldorsen et al. (1996) found that there was only a 50:50 level of agreement between GPs about whether or not to sick-list the case histories presented to them which were about non-specific musculoskeletal disorders with subjective complaints. The authors noted that this level of agreement suggests a random level of decision making about sickness certification for musculoskeletal disorders without objective pathology. They argued that this is a remarkable and worrying finding, although they did caution that GPs may behave differently with real patients than with the research study’s vignettes.

Of course, pain is subjective (Merleau-Ponty, 1962); even if the doctor can access evidence of physical pathology, from an x-ray or MRI result, the effect in terms of pain can vary from patient to patient, according to sociological, psychological and biological variables (Waddell, 1998), so the Haaland Haldorsen random level finding is not so extraordinary. But even if doctors abide by the dictum that “pain is what the patient says it is” (Meinhart and McCaffery, 1983), they still have to worry about how the patient communicates their complaint and then how to decide if workability is affected. Many sick-listing studies show that doctors feel uncomfortable with pain’s subjectivity as this uncertainty renders the capability decision more complex than if the patient had a clearly defined disorder. Alexanderson and Norlund’s (2004) systematic review showed that GPs have the greatest difficulty making a decision whether or not to sick-list in relation to common mental health problems and musculoskeletal disorders for this reason. Arrelov et al. (2007) came to a similar conclusion when studying orthopaedic surgeons and physicians. They found that doctors experienced sick-listing for musculoskeletal disorders as particularly problematic “when patients regard themselves as unable to work due to complaints that are hard to objectively verify for the physician” (p.2). This language could be quibbled with if one argues that all pain is subjective. However, Arrelov et al. (2007) were exploring the extra discomfort doctors felt when confronted with reported pain for which there was either no observable pathology or for which the observed pathology bore little correspondence to patients’ reports of symptoms. These doctors were uncomfortable
with combining their roles policing state benefits and being the patient’s advocates and this discomfort increased when doctors felt they could not make objective clinical decisions.

Similarly, von Knorring et al. (2007) carried out content analysis of focus groups with doctors and reported that doctors found sick-listing pain patients particularly problematic. The doctors worried that they did not know how to treat and manage patients with physical pain that was “difficult to diagnose” (p.26) with a key quotation reported from one participant: “there’s nothing, no investigations or tests or the like that can verify whether it actually is the way the patient describes it” (ibid). The language “difficult to diagnose” is interesting at it could be argued that pain is easy to diagnose, by asking one’s patient if they are in pain, so this phrase may hint at problems with GPs trusting their patients’ reports. The systematic review by Werner et al. (2012) found that doctors increased the duration of certification when physical findings such as sciatica were present: this could be an example of doctors feeling more comfortable at having data other than patients’ self-reports to go by. However, even in cases where a pain diagnosis has been reached, Nachemson and Jonsson (2000) showed it can be very difficult to assess the severity of symptoms. This may also make GPs uncomfortable with their role in the sickness certification process.

Nilsen et al. (2011) used focus groups to explore how GPs decide whether or not to sick-list a patient with a subjective health condition, including chronic pain conditions with no observable pathology. Nilsen et al. (2011) found that GPs specifically reported that avoiding conflict was a motivator in giving patients with subjective health complaints sick notes, even if the GPs did not feel this was in the patients’ best interests. Nilsen et al. (2011) recruited GPs to their focus group study when GPs were attending a course dealing with sickness certification for patients with subjective health conditions. It is possible that these GPs found sickness certification especially difficult, hence their attendance on this course, leading to possible systematic bias in the results. Alternatively, it may be that these GPs were simply more interested in improving their sickness certification practice, or were on the course for other reasons not reported in the paper. Whichever, the study provided extensive and rich data from forty eight doctors, most of whom reported that sickness certification consultations with patients with subjective health conditions were extremely challenging. GPs said that they had to trust patients’ stories, which largely they were able to do, but they missed objective evidence upon which to base decisions. GPs reported that how well patients could enact pain and engender sympathy were crucial elements as to whether or not a sick note was given, but that these things might be dependent upon patients’ skills just as much as on how unwell they were feeling, which is problematic.

**Conclusion and research questions so far**

The complex issues above result in several problematic outcomes for the sick-listing process. Doctors report feeling pressurised to give sick notes by the patient, to withhold them by the Government, and that chronic pain conditions exacerbate the uncertainty of the capability decision which is anyway complex and difficult. There is some evidence that doctors trained in OH and/or working within the biopsychosocial perspective sick-list less, in ways that perhaps do not unduly distress them or their patients. They are able to apply these bodies of knowledge to help themselves and their patients see if work could be part of a reparative solution. However, many doctors still appear to err on the side of caution and either sick-list on demand (Hussey et al., 2004) and also out of compassion if they are unsure of the pain condition’s likely outcome (Wrapson and Mewse, 2011a). This may make symptoms worse in the long run (Waddell and Aylward, 2005). Patients can feel invalidated by simply experiencingsick-listing, as they are positioned as supplicant, having to describe both their pain symptoms and workplace, and if the doctor does not agree with them, then it is as if their self-report data are not being trusted (Wrapson and
Mewse, 2011a; Coole et al., 2010b). Relatively little has been written on patients’ perspectives of sick-listing compared to doctors’. Although more is known about doctors’ attitudes to sickness certification, there is not much about how either party constructs and negotiates meaning within the general practice sick-listing consultation for chronic pain conditions: the two empirical studies in this thesis begin to address this gap. Also, little has been written on whether and how doctors persuade patients to be sick-listed who are determined to stay in work and how doctors and patients report this experience: this is discussed in the results of study one (chapter seven).

The research questions arising from the work of the thesis so far are:

- How do GPs describe their experiences of sickness certification for chronic pain?
- What are the difficulties they face and what strategies do they employ to address them?
- How do patients with chronic pain describe their experiences of sickness certification?
- What are the difficulties they face and what strategies do they employ to address them?

Constructing the problem of sickness certification from the policy perspective has been simple: the rising rates of sickness certification must be brought down. This is understandable, even commendable, given the evidence that starting a sick note is an extremely powerful intervention that may be wholly appropriate but that also may lead to long-term incapacity and worklessness (Waddell and Burton, 2006). Policy-makers know that GPs are usually the gatekeepers to sick-listing so they have been targeted as key agents of change, as they are in a strong position to explain to patients why appropriate work is good for them. However, the research discussed in chapter two highlighted caveats to the finding that even safe and appropriate work is beneficial to health outcomes and the policy construction of sickness certification has diminished these. This chapter has shown that complex negotiated processes such as the doctor and patient deciding whether or not sickness certification should occur are difficult to address through the sometimes blunt instrument of policy-making, but this has not stopped the UK government from attempting to do so. The next chapter therefore considers the policy response to sickness certification.
Chapter Four: The UK Policy Response to Rising Sickness Certification Rates

Introduction: Implications for sickness certification from reviews on work and health

Chapter two discussed three seminal reviews showing that “safe and accommodating” work is good for the mental and physical health outcomes of most people and that workers generally do not have to be one hundred per cent fit to return to work (Waddell and Burton, 2006, p.ix; also Black, 2008 and Black and Frost, 2011). Chapter two also discussed important caveats to these messages e.g. that there are a minority of people who may experience contrary health effects from work and be better off not working. However, Waddell and Burton (2006) found that early return to work (or staying at work) is beneficial for the health and well-being of most employees with musculoskeletal disorders. They also found that temporary modifications to work and better communication between the workplace and healthcare systems facilitate return to work for these employees. Waddell and Burton (2006) reported less clear evidence for people grouped as “sick and disabled” but still showed “broad consensus across multiple disciplines and also disability groups, employers, unions, insurers and the main political parties…that job retention or return to work are desirable goals to maintain or improve quality of life and well-being” (Waddell and Burton, 2006, p.20). A few of the documents they reviewed to arrive at these conclusions specifically discussed sickness certification. A discussion paper by Ford et al. (2000) and policy document by the DWP (2004) were both explicit that patients are often best served by clinical management designed to keep them working. These documents implied that historically doctors have not done this as much as they should.

Similarly, the review by Black (2008) noted that sickness certification often reflects an assumption that illness is incompatible with working. She argued that GPs sign sick notes too easily, but recognised that they do so “because they feel they have no alternative available” (p.68). She proposed the fit note as a way of focussing on identifying and promoting fitness for work and argued it should be electronic as a means of improving stakeholder communication and data collection. She also proposed better external services to which doctors could refer patients, such as a multi-agency Fit for Work Service, to help doctors feel that there are alternatives to sick-listing. Coole et al. (2010a) surveyed GPs who responded to patients with work problems due to low back pain. The researchers reported that only 25% of GPs they surveyed thought that return to work services for lower back pain patients were even adequate. The researchers concluded that Government expectations of better sick-listing management by GPs were unrealistic in the light of this. The eleven Fit for Work Service pilots have been successful (see below). However, only a very few GPs nationally can access them at present. Seven of the services will continue until 2013 but no other plans have been announced.

Writing in 2011, Black and Frost stated that there had been some, but not enough, progress with sickness certification, and vocational rehabilitation services. Doctors were held accountable when the researchers found that the fit note facilitates “an opportunity to give advice on practical measures to enable return to work. Currently, however, many people are declared completely unfit. Doubtless warranted in particular circumstances, in many other cases this holds back people from work, inhibits employers from helping people return, and might not be in the employee’s best long-term interest. We have, therefore, made recommendations to improve sickness certification” (p.5). Their recommendations are discussed below. They also implied that people themselves may not want to return to work: “we acknowledge that some of what we are proposing will put more pressure on people to return to work, but we hold that in many cases this would be in their own best interest, not just that of employers and taxpayers” (ibid.). This review is one of the most explicit in stating that doctors, patients and employees need to change their views and recognise that return to work is more appropriate than sick-listing for many people.
Sickness certification has therefore been constructed as problematic in these reviews on work and health. Rates have been rising over the last few decades, for the kinds of common health problems with which people are often better off remaining in work (musculoskeletal and minor mental health issues). These reviews have had a huge effect on Government policy towards sickness absence and specifically towards sickness certification in general practice. I now debate the formation of policies, and evidence into practice, including training GPs how to handle patients’ requests for sick notes and improving communication between stakeholders. I consider some early evaluations of these policies, as well as what they assume and what they omit. Finally, I reflect on whether some of the policy issues are teething problems or whether a more radical extension to the policy approach could be useful.

4.1 What can be done? The formation of policy solutions
4.1a Evidence into practice: work is good for you

It was the UK Labour government, in power 1997-2010, who commissioned Waddell and Burton’s 2006 review, *Is Work Good for Your Health and Well-being?* The same Government commissioned Dame Carol Black to conduct her review of the health of Britain’s working-age population, *Working for a Healthier Tomorrow*, published in 2008. The Labour government also set up the cross-government Health, Work and Well-being Strategy Unit (HWWB) to discuss the issues raised by these reviews and to implement the reforms they proposed. The current UK coalition government, which came into power in 2010, accepted the policy recommendations around sickness certification from these reviews and commissioned another, by Black and Frost (2011), to obtain up-to-date information and the reviewers’ expert opinions. Some of the documents analysed in these reviews were commissioned or written by Government agencies (e.g. DWP 2004 was written by their Chief Medical Advisor; it cites statutes but no academic research although its language is authoritative and its authorship lends its statements weight). Some of the documents analysed by the reviews were academic research papers of different types, including the discussion paper by Ford et al., (2000), published in the British Journal of General Practice, and many qualitative papers and systematic reviews were also considered. Some of the academic researchers have government links (e.g. one of the Ford authors is both academically and NHS affiliated) and many of the DWP papers cite academic work or are otherwise transparent about how they collected evidence (e.g. Hann and Sibbald, 2011). In other words, there is no clear distinction in all the documents between academic work and policy-making, and many were not Government commissioned. In this way, the Government has not been entirely partisan simply by so completely accepting the policy recommendations in these reviews. The reviews strongly assert that lower sickness certification rates are not only good for those individuals who may have been disadvantaged by staying off work, but also good at an economic level for the whole of society. The reviews are also clear that there is a small but important minority who are exceptions to this rule, and may be better off at home, but this caveat has been diminished in the formulation of policy solutions.

The UK Labour government responded to the Black review by designing a multi-faceted attack on rising sickness certification rates, to happen simultaneously (DWP and DoH, 2008). The main initiatives relevant to sickness certification were: a national education programme aimed all stakeholders involved in sickness absence: a Fit for Work Service; the paper sick note to become a paper then electronic fit note; and training for GPs on the new fit note. The Labour government began implementation of all of these apart from the electronic version of the fit note which was delayed several times, and is due to roll out nationally in 2013 (RCGP, 2012a); the coalition government has continued with these initiatives and taken over implementation of the electronic fit note.
4.1b The national education programme

An important element in policy implementation to reduce sickness certification is the national education programme aimed at all stakeholders involved in sickness absence—GPs, employers, workers, OH and HR professionals. This is primarily based online (e.g. DWP, 2012c). This website contains guides for four groups: GPs, written jointly with the British Medical Association (BMA) and Royal College of General Practitioners (RCGP); OH professionals, written jointly with the Faculty of Occupational Medicine and the Society of Occupational Medicine; employers, produced in partnership with the Chartered Institute of Personnel and Development, the Confederation of British Industry, the Federation of Small Businesses, Acas (Advisory, Conciliation and Arbitration Service), the Association of British Insurers and EEF, the manufacturers’ organisation; and finally guides for patients written by the DWP alone.

These organisations have produced a wealth of resources to assist their subscribers in taking on board the work and health messages of the national education programme. These include: the HealthyworkingUK website, run by the Royal College of General Practitioners (RGCP, 2012b); detailed guidance published in the BMJ on how to complete fit notes, including the wording of questions GPs could use to identify the need and scope for work modifications, and the wording of advice they could write on the notes (Coggon and Palmer, 2010); and professional magazines for HR, OH and general line managers running updates on guidance and issues for their readership (e.g. Personnel Today, 2011). These sources acknowledge there are still difficult issues to consider but they do so to differing degrees. On the one hand, the RGCP website has whole e-learning modules on how to make difficult decisions about workability and also on patient-practitioner communication, recognising that these are challenging for GPs. On the other hand, the Government resources are less accommodating towards such difficulties, highlighting the positive effects expected from the fit note. In summary, this education policy is designed to make all stakeholders believe that (good) work is good for us. Its other facets then discuss mechanisms to keep workers at work i.e. GPs to handle patient requests for certification better, patients to want to stay at work more, employers to adapt their workplaces to facilitate retention.

4.1c The Fit for Work Service

The second strand of the Government’s response to rising sickness certification rates was to take up Dame Carol Black’s recommendation of creating a Fit for Work Service, providing early multi-disciplinary interventions using the biopsychosocial model to aid return to work. Eleven pilots were set up in 2010, providing personalised, case-managed clinical and non-clinical support to help people return to or remain in work. Black also argued that employers must also contribute to a better system by improving their sickness absence and return to work policies. The employers’ sections of the national education programme provide information on how to do this (DWP, 2012d). This site includes tools for employers to make a business case for improving work absence and case studies of companies who have improved employee well-being in some way.

4.1d From sick to fit note

The third element of the policy response to rising sick-listing rates has been the change from sick note to fit note, and shortly to electronic fit note, as outlined in chapter two. It may be remembered that the fit note replaced the sick note in April 2010. Briefly, it is designed to focus on capacity not incapacity. By focusing on what people can do rather than what they cannot, the hope is that more people will return to work even if they require reduced or revised duties. GPs can still tick the box stating that a patient is not fit for work, but the other option has changed from stating one is “fit for work” to the wording that a patient “may be fit for work taking account of the following advice”. Four options follow: a phased return to work, amended duties, altered hours and workplace adaptations (see appendix two for a sample of the new fit note). The electronic fit note is planned to start in
July 2012 (postponed from 2010 due to technical difficulties), with national roll-out completed by 2013 (RCGP, 2012a).

4.1e Training for GPs on work, health and well-being

The DWP and partner organisation guides referred to in section 4.1b above could be considered training in a broad sense as these simple online and paper guides are meant to guide GPs through the new fit note process and also raise their awareness of the importance of patients remaining in work if clinically and practically possible. The General Medical Council (GMC) website has clear learning outcomes for trainee GPs including generic communication skills training but nothing specifically on work, health and well-being or sick notes (GMC, 2012). However, there are two specific sources of interactive training on sickness certification, embedded in the context of work, health and well-being. The RCGP provides half-day training workshops for GPs, but they have to take time off to attend about which some were unhappy (Wainwright et al., 2011). This article reports some of the findings from study one. Chapter seven expands on a selection of these and discusses others which were not in the article.

Additionally, there are several online modules which have very recently been developed on sick-listing within the context of work, health and well-being. These are on the HealthyworkingUK website, run by the Royal College of General Practitioners (RGCP, 2012b). The training covers advising on fitness for work, supporting rehabilitation, worklessness and unemployment (highlighting their risks and the benefits of work) difficult decisions assessing fitness for work, (including how employers can manage ill health as well as GPs) and communications and relationships with patients. There does not appear to be anything substantial on communicating with employers. GPs can claim CPD points for completing these modules, which can be worked through at their own pace from any computer.

4.2 Are the new policies working?

4.2a The national education programme

Multiple organisations representing stakeholders in the sickness certification process have collaborated in producing the Government’s national education materials, which suggests that the main messages have been taken on board by these organisations. Researchers and doctors themselves have written more mixed letters and editorials. Gabbay (2011) wrote an editorial arguing that GPs were finding fit notes challenging but have the skills to manage this, not least as many are employers themselves, and thus have that extra perspective. He emphasised that GPs must take a more active role in vocational rehabilitation as they are still the healthcare professionals that tend to begin the sick-listing, hence have opportunity to influence patients’ pathways at an early stage, and may facilitate the avoidance of long-term disability. Others have argued for widening who can sick-list in order to reduce the burden on GPs (Niven, 2004) and some researchers argue that sickness certification should be removed from the role of the doctor as the doctor must preserve their on-going doctor-patient relationship, and they cannot know enough about OH (Parker, 2008). Chapter seven, which reports the results from the thesis’ first empirical study, discusses why doctors may agree with the ideas promulgated by the national education programme around work being good for us, without wishing to apply it to all patients.

The national education programme targets doctors’ beliefs about back pain and work, using case studies of lower back pain patients, (for whom serious pathology or ‘red flag’ conditions like cancer have been ruled out), to show that working, and movement at work, can be beneficial for such patients. It does this in the context of general knowledge about work, health and well-being. Watson et al. (2008) showed that certification for back pain was better explained by GPs’ overall propensity to give sick notes rather than their back pain beliefs per se. Watson et al. (2008) therefore argued that “a campaign directed only
at back pain beliefs might be less effective than targeting the factors which drive sickness certification in general” (p.315). The national education programme is attempting to target such general drivers. However, other studies such as those by Linton et al. (2002) and Coudeyre et al. (2006) discussed in chapter three showed that GPs’ pain beliefs strongly affected their return to work advice; we need further research into this important area, which was also the conclusion of a review by Main et al. (2010).

There is evidence that employers agree in principle that measures to promote health and well-being at work are socially important and commercially useful, but lack the time to manage these issues and also want more access to “advice via neutral intermediary services” (DWP, 2011, p.7). Chapter eight, which reports results from the thesis’ second empirical study, engages with this issue further.

4.2b The Fit for Work Service

The Fit for Work Service is due to be fully evaluated in 2013; interim evaluations commissioned by the DWP reported qualitative evidence that the service helped people get back to work more quickly than they would otherwise have done (Hillage, 2012). The Fit for Work Service evaluation specifically mentions sickness certification, giving one example of how the service advised a client to discuss reduced hours and lighter duties with their GP. Hillage (2012) also discussed various benefits GPs reported they gained from the service. These included someone else having more time to discuss return to work with patients than GPs could do in their ten minute consultations, and the provision of expert workplace assessments. GPs also commented that the service was able to assess patients more holistically, as they had access to the employer and the workplace. One GP commented:

“I can't give specifics on my fit notes, whereas I think that the FFWS people could go and make it more specific so the patient knew what they were expecting or asking and the employer could, there could be dialogue’. (Hillage, 2012, p.64).

All of these benefits meant GPs felt more confident about sick-listing less as they had recourse to excellent services. GPs were also very pleased that the service saved time in repeat appointments with sick-listed patients, as they reviewed them less frequently. Some GPs said that the service might also prevent patients from going onto long-term sick leave, and was seen “as a constructive way to help GPs who were sometimes criticised for issuing sick notes” (ibid, p.64). Finally, GPs thought the service might prevent patients developing chronic conditions if they could access services more quickly. Despite such positive evaluations by GPs and patients, there does not appear to be any national roll-out plans for the Fit for Work Service.

4.2c The fit note

Black (2008) argued that both forms of the fit note (paper and electronic) would improve communication between all stakeholders. This was much needed, as before the fit note, there was an established body of literature showing that GPs and employers do not communicate well with each other. As early as 1989, a respected review by Tellnes recommended more contact between all stakeholders, including more workplace visits, and setting up what he termed local inter-professional cooperation groups to aid return to work. More recently, Coole et al., (2010a) used a questionnaire survey to study how GPs responded to patients who presented with work problems due to low back pain. They contacted over 440 GPs in Nottingham, obtaining a 54.5% response rate. They found that only 2.5% of respondents initiated contact with employers regarding patients’ work and only 10.4% with other healthcare practitioners also treating the patient. This finding may have been limited by the response rate. Also, it was likely that GPs who were interested in work and health replied, which may have biased the responses, as perhaps those GPs who did not respond contacted employers even less. From their study, Coole et al. (2010a) concluded that GPs were not really engaging with vocational rehabilitation. They
implied that this was the fault of GPs, but, a later paper by Coole et al. (2010b) reported that GPs feel too time-pressured to contact employers, suggesting they are suffering from the structural constraints of a heavy workload. A DWP report showed that almost half of employers surveyed stated that they found sick notes “not very useful or not at all useful” (Young and Bhaumik, 2011, p.38) which may be why employers did not respond to GPs. An analysis and debate piece by Thomson and Hampton (2012) concluded that the fit note has not yet led to improved communication between GPs and employers; they suggested an e-note would be more likely to as it would be easier to monitor and analyse. We need to know more about the interplay between GPs’ views of employers and employers’ views of GPs, both in general and with reference to the paper and electronic versions of the fit note. These questions are explored in the study reported in chapters eight and nine.

Before the fit note went live, Sallis et al. (2010) showed that in a trial of the prototype fit note versus sick notes, GPs signed more patients as fit to work on the new system. Sallis et al. (2010) gave GPs two vignettes, one of which concerned a male in his forties with back pain. He was a warehouse supervisor, whose job involved administration, team management, regular walking and heavy lifting. GPs using the trial fit note were more likely than those using the old sick note to assess the back pain case as ‘fit for [some] work’ (OR) = 13.4; 95% CI = 8.9 to 20.2; \(P<0.001\). ‘Amended duties’ was the most commonly used option, which makes sense considering that there is an objective evidence base for helping back pain sufferers to stay at work. However, Sallis et al. (2010) reported a low response rate, which may make the results less generalisable. This study was done with vignettes, not patients, but has been often cited as evidence that GPs would respond to the fit note as planned i.e. sign less patients off work (e.g. Chang and Irving, 2009; Gabbay, 2010).

Also before the fit note went live, Coole et al. (2010a), in their survey of how UK GPs manage low back pain patients, concluded that we know little about how GPs manage this patient group and even less about how GPs might use the new fit note. They suggested that greater knowledge in these areas would increase the likelihood of the success of the fit note and related Government initiatives such as the national training programme for GPs. The empirical studies in this thesis address this knowledge gap.

Very little research on the use of the new fit note in clinical practice has yet been published (last search August 2012). However, there is some. Seventy-one per cent of organisations surveyed for workplace health issues did not think GPs used fit notes any differently from sick notes (CBI, 2011). More positively, Hann and Sibbald (2011) analysed data from the 2010 National GP Worklife Survey of 1405 GPs. They found that 61% of doctors reported positive impacts of the fit note on the quality of consultations although 38% reported no change to their practice. Those who had received training reported more confidence in dealing with return to work, but there was no significant association between training and reporting positive fit note impacts. Thomson and Hampton’s (2012) debate and analysis piece on the fit note pointed out that as yet we know little about how it is being used in practice, but more aids for GPs are becoming available. These aids include pages from the DWP website on the fit note, scripts suggested in BMJ articles (Coggon and Palmer, 2010) and the new, extensive website on health and work by the Royal College of General Practitioners (RGCP, 2012b). Fylan et al. (2011) interviewed 45 GPs, reporting that doctors found the fit note useful for musculoskeletal conditions which could be helped via modified duties. However, doctors perceived that fit note guidance has been too generalised, and that employers need very specific information from GPs which they did not feel they had been encouraged to give. They wanted more guidance on where accountability lay if there were negative outcomes from patients’ returning to work. Wainwright et al. (2011) conducted in-depth qualitative interviews with 13 GPs. They found that GPs liked the fit note’s rationale but reported barriers to use including worries it
could exacerbate patient conflict, lack of support from employers and rehabilitation services and feeling unconfident about OH knowledge. Welsh et al. (2012) reported very similar results to Wainwright et al. (2011) using similar methodology. They emphasised that GPs perceived employers’ inaction as the major stumbling block to effective fit note use. They reported GPs found that the layout of the fit note, with prominently printed suggestions for work modification, assisted negotiations with patients. However, like Wainwright et al. (2011) they cited “the gap between policy-making…and the reality of everyday healthcare as an important contributor to the negative perceptions and scepticism that some GPs hold towards sickness certification changes” (p. e366). This is an important point which shows the limitations of “naïve rationalism” as a policy-making framework (Russell et al., 2008). This is explored in chapter five and is characterised partly by the notion that policy-making is all about attaining and putting into action best research evidence (Russell et al., 2008).

4.2d GP training
The training available to GPs on sickness certification, embedded in work, health and well-being is available in three modalities, as noted above. These are: simple online and paper guides from the DWP and partner organisations; half-day workshops run by the RCGP and finally online Continuing Professional Development (CPD) modules also developed by the RCGP.

Nothing has been found formally evaluating the guides, other than doctors’ perceptions they are too generalised, in the study by Fylan et al. (2011) reported above. The DWP reported the guides are to be re-written and re-released in the light of the introduction of the electronic fit note (DWP, 2012a). However, the systematic review by Werner et al. (2012) discussed how healthcare practitioners have been shown to be largely unaffected by dissemination of guidelines.

The half-day RCGP workshops were created and co-delivered by Dr Debbie Cohen, a researcher who previously practised as a GP. Chang and Irving (2008) evaluated the early version of the workshops for the DWP and summarised them as successful, for example as they showed GPs the importance of seeing the social as well as medical aspects to the consultation. However, as Coole et al. (2010a) pointed out, within the detail of Chang and Irving’s report, it is noted that “a substantial number of GPs who reported back remained ‘not particularly’ or ‘not at all confident’ on advising patients on management of conditions caused by work (43%), advising on modifications or adjustments (45%) and health and safety issues (49%) and advising on fitness for work (23%). None of the participants felt ‘very confident’ in the first three categories, with <10% feeling very confident on advising on fitness for work.” (Coole et al., 2010a, p.35; taken from table 2.3, ‘confidence in dealing with issues’, Chang and Irving, 2008, p.15). Nonetheless, Chang and Irving (2008) reported that levels of confidence had risen immediately after attending the workshop and remained high at two months’ follow-up. Chang and Irving (2008) reported that GPs wanted more on how to handle problems such as recalcitrant patients and uncooperative employers, as well as wanting more knowledge about the benefits system. I was kindly allowed to attend one of these training sessions by Dr Cohen in March 2010 and it did include both of these areas; problem consultations were addressed by role-play and links to benefits knowledge were provided. Gabbay (2011) stated that the training addresses the process of certification, which is important, and elsewhere in his editorial suggested GPs find conflict the hardest element. He did not appear to be criticising the workshops. In response, Cohen and Aylward (2012) stated it was important to correct what Gabbay (2011) had said about the workshops, noting that they “specifically focuse[d] on the conversation between GP and patient and not the certification itself” (p.67) as this is what GPs found most difficult. They stated that further evaluation of the training was soon to be published, but as of August 2012 it had not been.
The online CPD modules came on stream early 2012 and nothing has been found evaluating them (last search August 2012). These are exactly the sort of interactive modules that GPs in study one wanted, which did not exist in 2010 when the study was conducted; future research could usefully evaluate their efficacy.

Not enough is known about the effects of relevant postgraduate training in OH on sick-listing. Such training has been associated with lower rates of certification in some studies (Hiscock and Ritchie, 2001; Tellnes, 1989). A literature review by Soderberg and Alexanderson (2003) of physicians’ sickness certification practices found that physicians trained in OH certified shorter sick leave, as they felt confident in applying their specialist knowledge of the workplace in consultations. However, a more recent study found mixed effects of extensive OH training. Money et al. (2010) conducted telephone interviews with 31 GPs who were trained to diploma level in occupational health (Diploma of Occupational Medicine, or DOccMed, Royal College of Physicians) and already participated in a UK-wide surveillance scheme studying work-related ill health. One of their findings regarding GPs’ perspectives on who initiates sick-listing was discussed in chapter three. Their study also researched the effects of being an OH specialist. Some of the GPs reported that their role as patient advocate was the most important element of sickness absence consultations, hence they were very likely to give a sick note on demand. This is a worrying finding for those within Government seeking to change sickness certification behaviour amongst GPs, as the DWP assumption appears to be that training GPs in OH issues will result in fewer sick notes being given.

Money et al. (2010) also reported that some GPs had indeed found that greater understanding of the potential health benefits of work, acquired via OH training, equipped them to better assess patients’ fitness for work and that they issued fewer sick notes (concerning both mental health, at 47% of sick notes given, and musculoskeletal disorders, at 37%) as a result. These GPs said they felt more confident in handling conflict with patients as OH training enabled them not to simply accept what patients said but delve into their work tasks and possible workplace adaptations in more detail. Importantly, some GPs also reported that OH training was able to link their feeling that they were the patient’s advocate with their ability to resist giving sick notes on demand. This was because the GPs felt very confident in their knowledge that good work is good for many patients, and also felt confident explaining to people that falling into long-term incapacity is harmful if an extended period of sick leave is not initially necessary. This is a positive finding which is in line with Government thinking that providing OH knowledge can change sickness certification practices. Perhaps more GPs should be encouraged to do this OH Diploma, by stronger support for it as part of their CPD. Money et al. (2010) found that only 4% of GP have this OH diploma: it requires about 10 hours’ study per week for six months, a considerable investment in a GP’s time. As Chang and Irving (2008) noted, a half-day workshop such as the RCGP ones may be a more pragmatic solution, although evaluation of these workshops is still on-going. Cohen et al. (2009) reported GPs’ consensus that the lack of training in OH and sickness certification led newly qualified GPs to believe that these topics were not very important. Simply offering training in these areas may therefore be beneficial.

In summary, not enough is known about how training in general affects GP behaviour and how OH training in particular may affect GP certification behaviour. Lofgren et al. (2011) reported that doctors stated they gained competence in sick-listing through clinical practice, not training. Werner and Cote (2009)’s review studied if it is possible to change a doctor’s sick-listing pattern and found two studies which targeted doctors with updated knowledge about back pain and various treatment interventions and were unsuccessful in reducing sickness absence (Werner et al., 2008; Jellema et al., 2007). Money et al. (2010) showed that OH training only enabled some, not all, GPs, to issue fewer sick notes. Also, the assumption in these studies is that OH training will result in improved assessment of
fitness to work, which will in turn lead to fewer sick notes being issued. This may be true, given that many earlier studies have reported that GPs give out sick notes on demand to avoid conflict even if they are uncomfortable that this was not in the patient’s best interest (Hussey et al., 2004; Hiscock and Ritchie, 2001; Nilsen et al. 2011). Yet it has also been found that GPs find it very hard to assess functionality for subjective health conditions (Tellnes, 1989; Larsen and Jenkins, 2005; Nilsen et al. 2011) so it is not yet clear if OH training will assist GPs to assess chronic pain patients with no observable pathology with greater confidence, better abilities to manage conflict and with necessarily more appropriate outcomes for patients.

4.3 What do the policies include?
4.3a Improved balance between knowledge and skills

Since the Government produced its first fit note guides and training materials, there has been a trajectory away from simply supplying knowledge about sickness certification and work, health and well-being, and towards recognising that we need to address how doctors raise difficult topics, and manage patients’ expectations. For example, ten years ago, Sawney (2002) explored issues for certifying medical practitioners in the UK, particularly for GPs, who frequently provide medical advice to their patients on fitness for work. Sawney reproduced a table of factors, clinical knowledge and skills relevant to sickness certification, according to the DWP. This table contained five topic headings in which GPs must be knowledgeable, such as the nature of the patient’s medical condition, and two skills, which were negotiating and managing conflict. Under the topic heading were thirteen areas of competence whereas the skills heading only expanded into three. Whilst knowledge of medical conditions, legislation and benefits are important, and doctors nowadays still say they need more training on this (Chang and Irving, 2008), most research suggests that doctors want more help with skills training than simply knowledge gathering, which they can do alone. One such study is reported in detail, below, as it was a robustly designed and executed study of over 4,000 physicians, including primary care doctors.

Lofgren et al. (2010) analysed questionnaire data from Swedish doctors concerning what they wanted to know about sickness certification, for all conditions. The study population was all types of doctors in two areas of Sweden, including doctors from primary care, psychiatry, occupational health services, orthopaedics, and surgeons. Analyses of association showed two groups of correlated questionnaire items, so the researchers created two indices, a knowledge index and a skills index. They termed “knowledge” as explicit information that can be verbalised and communicated to others, whereas “skills” were seen as implicit knowledge. Knowledge items included sickness certification rules, including all stakeholders’ responsibilities, and other compensation systems. As an example of a skill, Lofgren et al. (2010) reported that some physicians described assessment of functional ability as being in the back of their minds. Other skills in the study were listed as understanding work demands in different occupations, assessing the optimum length and degree of sick notes, handling conflict with patients and devising optimum action plans. Some of these items seem to include knowledge as well as skills, but it is probably impossible to conceptualise items as wholly either skills or knowledge; the categorisation by Lofgren et al. (2010), very experienced researchers in this field, appears plausible.

This study found substantial differences between the needs of different types of clinician. A higher percentage of physicians in primary care and psychiatry reported needing more knowledge and skills compared to other doctors, presumably because they come up against sickness certification as an issue more often. Interestingly, the primary care doctors reported a greater need for skills, as opposed to knowledge, compared to all the other doctors. Lofgren et al. (2010) suggested that this could be because these
doctors already had substantial knowledge but that being confronted with difficult cases in
general practice made them feel that they needed relatively more skills than knowledge.

The researchers reported that no physicians felt strongly that they needed training on
how to complete the sick notes themselves, whereas it is known from other studies that
stakeholders do complain about the poor quality of sick note completion and that GPs
admit to this (Hussey et al., 2004). Wynne-Jones et al. (2010b) found doctors wanted
more knowledge to appropriately discuss working with health conditions with patients;
71% of the 1,000 doctors surveyed reported having no training in certification, either
informal or as part of formal OH training. Over half wanted more training, and of these, the
biggest proportion wanted training in dealing with patients demanding certificates, i.e.
relatively more skills than knowledge.

Much of the Government’s GP fit note guidance concerns how to complete the form
(DWP, 2010e). Whilst this is understandable as the form itself is quite new, the findings of
Loefgren et al. (2010) and Wynne-Jones et al. (2010b) suggest that future training
materials should consider giving more equal emphasis to both knowledge and skills, not
simply knowledge. The RCGP workshops and online modules at HealthyworkingUK do
now provide this, so the RCGP should be given credit for covering both skills and
knowledge; perhaps the new fit note guidance (forthcoming, according to the DWP
website; DWP, 2012a) should follow suit, or at least signpost the RCGP training.

4.4 What do the policies omit?
4.4a Policy into practice difficulties
The policies do not acknowledge that there is uncertainty over the effect of training
and over how and whether doctors follow guidelines, as discussed above: any training or
guidelines of reasonably high quality are presumed to have positive effects. If they do not,
it may be tempting to blame the trainees without considering what is known about why
they do not put into practice what they are supposed to have learned. The policies do not
acknowledge that even with good intentions to act, it can be difficult to apply knowledge in
practice, and this can also apply to evidence-based knowledge with which stakeholders
agree. For example, in a Scandinavian study, Kausto et al. 2008 showed that it was
difficult to arrange partial return to work (which the UK fit note aims to promote) probably
because it was not easy for employers to implement this within existing structures and
also because communication and collaboration between stakeholders was poor. In an
editorial for the BMJ, Verbeek (2009) referred to this study, warning that simply offering
the option on the fit note for partial return to work would not be a panacea to our sick-
listing ills. Indeed, it has been shown that small and medium enterprises (SMEs) find it
very difficult to accommodate what GPs write on the fit note, as they are often unable to
cope with adapted duties, whereas these can be more easily absorbed by big companies
(Young and Bhaumik, 2011).

Employability of people with chronic ill health is not considered in the work and health
training materials available to stakeholders, yet there is evidence employers do not recruit
people with ill health if people in good health are available (Wainwright et al., 2012). Also,
even if people are willing and able to work, reasonable jobs need to be available for them
to do, which can be challenging in a recession.

The policies attempt to change beliefs about work and health so that people accept
good work is good for us and that one does not need to be one hundred per cent fit to
work. For patients and employers, they do this by giving knowledge about the health
benefits of work (patients) and business case for reducing sickness absence (employers).
Yet it is difficult to change people’s beliefs by giving them knowledge alone. Werner and
Cote’s (2009) review of lower back pain sick-listing determinants found some studies
which had attempted to educate the public about the benefits of being at work and being
active throughout most types and degrees of back pain. One study examined a population-based media campaign which was conducted between 2002-2005 in two countries to change the beliefs about lower back pain. The campaign did not result in a reduction of sickness absence or other sickness behaviour compared to a control country (Werner et al. 2007). Werner and Cote (2009) found two other studies which researched media campaigns designed to highlight the benefits of staying active through an episode of lower back pain (Waddell et al., 2007 and Buchbinder et al., 2008). Both these studies found that media campaigns emphasising the benefits of staying active through an episode of lower back pain changed beliefs about activity and back pain but did not change sickness absence behaviour. Werner and Cote (2009) suggested that this is because general knowledge about a concept may be disregarded when one’s own back is hurting. This is returned to in the results of study one (chapter seven). Werner and Cote (2009) discussed how Ajzen and Fishbein (1997) reviewed and analysed relevant psychological literature and suggested that improving knowledge is insufficient to induce behavioural change. More recent work (e.g. Bandura 2000) suggests that we have to believe that positive results of any behaviour change will outweigh negative ones. Werner and Cote (2009) concluded that people may not believe that staying at work with back pain will be less painful than staying at home.

4.4b Roles, power and status in stakeholder communication

Evidence suggests GPs do not often contact employers (Coole et al., 2010a) and vice versa (Young and Bhaumik, 2011). As these researchers and others (e.g. Black, 2008, Buck et al., 2009) argue better communication between all stakeholders is key to improving sick-listing and return to work, perhaps the DWP guides and RCGP communication module on work, health and well-being could also include managing relationships between employers and GPs. The fit note guide for GPs (DWP 2012e) does not mention GP-employer communication at all; the patient is the conduit through which information is meant to flow. The fit note guide for employers states that “You can also write to the doctor for more information; however, bear in mind that you may have to pay for this service and a busy GP may not be able to respond to your enquiry immediately.” (DWP 2012f, p.20) Again, this guide recommends that the employer approaches the employee as the first port of call for clarification of anything on the fit note. This is sensible in terms of the employee being the subject of the fit note and because the employee was probably in the GP consultation (fit notes can be written after telephone assessment and in the light of other health professionals’ information, but mostly appear to be done face-to-face). However, this positioning of the employee as conduit relies on their ability to understand and communicate fit note information, and on good working relationships with line managers, HR and OH departments (if they have these). These elements may simply not be in place.

The DWP guides and the RCGP training do not consider in any depth how roles, power and status affect doctor-patient-employer relationships. There is evidence that employees and supervisors do not always feel they have productive relationships and that this can be difficult to change (Wrapson and Mewse, 2011b). Also, by the DWP employers’ guide reminding them that GPs are busy and may not respond quickly, it is alluding to some of the issues around power but not exploring them in a productive manner. Hillage (2012) showed that employers did not like the online resources available to them as they felt they were from non-neutral sources. The implication is that employers did not trust the agenda of the suppliers of the resources (mostly the DWP and Department of Health); we know employers have expressed concerns that relevant legislation is too much on the side of the employee and that there is legal uncertainty that needs clarifying (Black and Frost 2011). This issue emerged in study two, see chapter nine.
Some researchers and policy-makers expressed their hope that the change in language from “sick note” to “fit note” would refocus stakeholders’ minds from what people cannot do to what they can do (Black, 2010). The results of study one discuss this (see chapter seven). Research by Hiscock and Ritchie (2001), showed that the sick role has a powerful influence on how patients view sickness certification, and it is unlikely that the change from sick note to fit note alone will ameliorate its potency. This study and many others (e.g. Hussey et al., 2004; Verbeek et al., 2004) showed that patients are willing to come into conflict with GPs in order to get sick-listed, so strong was their motivation to enter the sick-role.

The UK government does acknowledge that there are areas of conflict and negotiation that occur in sickness certification and indeed one of its training leaflets provides GPs with some suggested lines of speech that they can use to manage conflict (Working for Health, 2010). However, Wainwright et al. (2011) found that not a single GP had come across these leaflets before the researcher displayed them as part of the interview process. Some GPs stated they had no time to look at them, whereas others took them away, reporting they were pleased that these scripts appeared to offer some recognition that sickness certification is complex. The main Government training document does acknowledge that “addressing work issues can be challenging as patients may have a pre-conceived idea that they need to refrain from work to get better. Often this is not the case” (DWP, 2010e, p.7). However, the document’s next few sentences provide a useful summary of the evidence that work is good for the health and well-being of many people, but then assumes that simply by presenting this evidence, the “challenge” of the consultation will be overcome and the new fit note legislation smooth to implement. The training document does not discuss any of the issues that chapter three’s review showed GPs find difficult in sick note consultations, such as how to manage conflict with patients and how to cope with subjective health conditions. Coggon and Palmer’s (2010) guidance, published in the BMJ, acknowledges the potential for conflict but merely states “doctors should not collude in what they have good reason to believe is malingering…[or] sometimes, reluctance to return to work stems from an erroneous perception that doing so will exacerbate the health problem or delay its recovery, in which case the doctor may be able to correct the misapprehension.” (p.1215). The article does not consider how a doctor should avoid “collusion” or what to do if misapprehensions are hard to correct.

Wynne-Jones et al. (2010b) noted that “avoiding conflict in the relationship with patients accounts for much of the problem of implementing evidence relating to the management of health and work” (p.348). This study looked at GPs and patients negotiating sick notes for all conditions, not just musculoskeletal disorders, but as the latter problems constitute the second most frequent reasons for being given a sick note, it is reasonable to apply the authors’ conclusion to the present discussion. Hussey et al. (2004) and Cohen (2008) also noted the importance of policy-makers recognising more clearly the conflict that GPs feel and providing better ways to manage it. Again, some movement towards this has been made by the RCGP e-health training modules (developed by Cohen) but not in the DWP literature so far.

In addition, when Watson et al. (2008) studied medically certified work loss, recurrence and costs of wage compensation for back pain, they noted that an additional problem for GPs is that “their relationship with the patient is continuous, unlike other health professionals who can put time limitations on treatment or indicate that their treatment is not appropriate” (p.318). The particular nature of the GP-patient relationship also needs more detailed consideration in sickness certification policy. Very few studies suggest that GPs are willing to damage their patient relationships by being overtly challenging. Doctors are caught on the horns of a dilemma; they must maintain good relationships with patients, whilst challenging many of their perceptions around work and health.
Doctors may also feel in conflict with the policy-makers themselves. Hussey et al. (2004) found that GPs were so disillusioned with the sickness certification system that they were uninterested in learning more about good practice, as they did not think it was possible to behave differently within the current set up. They expressed anger with those who created the system. This issue also emerged in study one, see chapter seven.

4.4c The subjectivity of assessing capability to work

Chapter three discussed how applying evidence-based knowledge about returning to work with some chronic pain conditions is challenging. Even with more objective pain conditions with attendant observable pathology, such as most types of arthritis, GPs felt that their assessments of patients’ ability to return to work were often subjective and disliked this (Larsen and Jenkins, 2005). Normmen et al., (2008) showed that even if GPs’ assessment of impaired work capacity was based on a view of patients’ functional impairments in relation to their jobs, functional impairment was not necessarily equivalent to reduced work capacity. Also, in the majority of cases, doctors had to rely on patients' descriptions of their work tasks, so GPs’ knowledge of these was second-hand. This made them uncomfortable, and their lack of OH knowledge and discomfort with this are not dealt with in any depth by the Government’s GP training booklet on the fit note (DWP, 2010e). This booklet states that “you do not need specialist occupational health expertise or a detailed understanding of your patient’s job to complete the form. The advice you give is on the functional effects of the condition within the limits of your knowledge and expertise” (DWP, 2010e, p.5). The new RCGP e-health training modules move further towards recognising that the capability decision is not always an exact science. This may be sufficient to reassure some GPs but the research by Normmen et al. (2008) suggested that others will continue to feel uncomfortable about the nature of their knowledge concerning patients’ jobs, which may impact upon the social negotiation processes surrounding sick note consultations.

4.4d The subjectivity of many chronic pain conditions

Many chronic pain conditions lack observable pathology and can be seen as contestable (Delvecchio Good et al., 1992; Wainwright et al., 2006). Tellnes (1989) reported lack of observable pathology was problematic for physicians and occurred in sickness consultations for 40% of back pain patients and 70% of chronic back pain patients. Chapter three discussed how when faced with subjective health conditions, GPs find it very difficult to refuse a sick note if one is asked for and also find the subjectivity itself worrying (Larsen and Jenkins, 2005; Hussey et al., 2004). Hence the contestability of chronic pain made sick-listing even more difficult for doctors. Even with the new fit note, which allows for more uncertainty than the sick note as a patient can be certified as “may be fit for some work” rather than definitely fit or definitely not, doctors are still required to assess how the chronic pain condition suffered by the patient in front of them may or may not affect workability and in what ways. Foucault (1973) reminds us that much of the work of medicine is not simply about observation but about interpretation, within current boundaries of knowledge. Simply giving GPs information that work is good for many pain patients is unlikely to deal with how GPs feel about subjectivity. Evidence from Arrelov et al. (2003) suggests that the legislative change from sick note to fit note will not work unless legislators re-frame sickness certificates from “objective foundations for decisions” to “subjective medical advice” (p.267). Arrelov et al. (2003) studied the effect of new Swedish legislation about sickness absence on physicians’ performance as certifiers. The legislation was meant to reduce costs of sickness absence by excluding non-medical criteria for sick-listing, and to promote both part-time sick-listing and faster rehabilitation. The study considered all conditions, but specifically examined musculoskeletal disorders, as these conditions constitute a large proportion of those on sick leave in Sweden, just as in the UK. Arrelov et al. (2003) found that there was very little change in practice and
legislation did not affect how more subjective cases of musculoskeletal disorders were certificated.

**Conclusion: policy teething troubles or limitations of the approach?**

It is too early to offer definitive evaluations of the policy response to sickness certification. It is, however, clear from early evaluations discussed above that stakeholders have largely taken on board the main policy messages that work is good for us, that we do not need to be one hundred per cent fit in order to remain at work and that therefore sick-listing rates could be reduced. However, there are many unresolved issues in translating this knowledge into practice. It also appears likely that the policy response has not yet sufficiently responded to the many factors which research suggests influence sickness certification for chronic pain patients. These include the GP’s desire not to damage the doctor-patient relationship and the difficulty of determining the degree to which reported pain diminishes capability for work.

More appropriate sickness certification is not just a matter of disseminating evidence to GPs, or aiding communication between stakeholders, but requires managing a complex and multi-factorial process of negotiation. Little is known about how this process applies specifically to sickness certification for chronic pain. The policy response has barely addressed how patients may enact their condition, nor why they may have certain aspirations and expectations about being sick-listed.

There is a strong cultural norm of behaving sympathetically towards people who are suffering (Wilkinson, 2005; Wainwright et al., 2006) and chapter three showed that many GPs err on the side of caution, signing patients off sick when they may be physically and mentally better off staying at work. It is very difficult for GPs to know which of their chronic pain patients might do better at work (or to contradict their patients view on this), and which of these patients may fall into the 5-10% for whom respite from work might be more beneficial,(Waddell and Burton, 2006). Government policies, and training around the new fit note, do little to address these issues.

It could be argued that the policy response is merely suffering from teething troubles which will be resolved by the recent move from a knowledge deficit model towards recognition that doctors require more training in negotiation skills and managing conflict. However, even with this shift in emphasis the policy response still omits many sociological issues, such as the nature of the sick role, who has power in micro-interactions and how macro organisations such as the healthcare system and the government can influence general practice consultations. Rather than small scale changes, a more radical policy review may be required to address the struggles for meaning attendant in many sick-listing consultations. On a macro level, we need to explore further how cultural themes shape the construction of acceptable pain-related work absence for patients with chronic pain (Kleinman, 1988; Waddell and Aylward, 2005; Wilkinson, 2005). On a micro level, we need to explore how protagonists respond to the current shaping of medical knowledge, and how these shape power dynamics within individual consultations (Foucault, 1973).

It is not known how GPs negotiate where their general skills and specialist knowledge begin and end, within the context of negotiating sickness certification for chronic pain patients. We need to consider if theoretical accounts of the GP-patient relationship can be applied to sickness absence negotiations for patients with chronic pain, and what these accounts tell us about possible policy deficiencies. We need to consider what sociological theories can suggest about this specific context of sickness certification negotiation for patients with chronic pain. By addressing these questions, we might be able to more fully assess the policy response to sickness certification for chronic pain patients, and identify other issues that may need to be addressed in order to better manage sickness certification for this patient group. Chapter five considers what medical sociology might
bring to the debate. The research questions posed at the end of chapter three, concerning the attitudes and beliefs that doctors and patients bring to consultations, remain relevant, but the way they might be answered has begun to change. This is considered in more detail in chapter five and the epistemological and ontological implications adopted for the thesis' empirical work are explored in the main methodology chapter (six).

The chapter has shown that we need to research doctors’ and patients’ views of the change from sick to fit note, as this is the most obvious policy initiative in response to rising sickness certification rates, which is tied in with the national education programme to persuade us that appropriate work is good for us, and with training doctors on the new fit note. Therefore, two new research questions were added:

- What are the attitudes and beliefs of GPs, regarding the introduction of the fit note, and education programme on work and health, for sickness certification for chronic pain patients?
- What are the attitudes and beliefs of patients with chronic pain, regarding the introduction of the fit note, and education programme on work and health?

It has also emerged from this chapter that we need to consider how employers fit into sickness certification (and employees, since not all patients will have jobs) and that this consideration needs to be framed in a way that will allow concepts of roles, power, status and conflict to be entertained. Therefore, some new research questions were added, designed to mirror the doctor-patient ones in terms of considering how people construct meaning in social interaction, and also regarding views on the fit note:

- What are employers’ and employees’ aspirations and expectations regarding sick leave for chronic pain and return to work?
- Do employers and employees think the GP-patient sick-listing consultation influences workplace management of sick leave and return to work?
- Do employers think they can, or should, influence the GP-patient sick-listing consultation?
- Do employees think employers and workplace characteristics can, or should, influence the GP-patient sick-listing consultation?
- Has the fit note changed employers’ and employees’ sick leave and return to work experiences?
Chapter Five: Key Sociological Concepts Relating to Sickness Certification and the Policy Response

Introduction

The aim of this chapter is to introduce key sociological concepts and theories that are relevant to the problem of sickness certification and the policy response to it. I posit that the policy response is a form of ‘naïve rationalism’ and argue for the adoption of a broader viewpoint that includes sociological perspectives on the social negotiation of meaning, and issues of knowledge and power. Sickness certification is a psychosocial phenomenon, influenced by pathology (if present), and comprising a process of social negotiations. These are shaped by normative expectations and aspirations which may have a more powerful influence than clinical guidelines, rational deliberation and legislation (Arrelo et al., 2003; Meershoek et al., 2007). Sociological concepts provide an insight into the policy response, and influenced the formation of my research questions, which aim to capture processes of social negotiation around the capability decision. Some concepts, such as the Parsonian sick role and Goffman’s concept of stigma, are established in the literature on chronic pain sufferers and appear in sick-listing research: I discuss how their import could usefully be considered when policy is being framed. Foucauldian notions of knowledge and power have not been applied to research on sick-listing for chronic pain, but have been to considerations of the identity of the chronic pain patient (e.g. see Eccleston et al., 1997; Armstrong, 1989); their relevance to sick-listing emerged from my critique of the existing literature as sickness certification is so bound up with stakeholders’ places in discursive formations. Bourdieu’s concept of habitus has been used by a few researchers such as Virtanen et al. (2000) to try to explain the socially negotiated processes which occur during sickness absence and became a useful concept to assist in the interpretation of my empirical findings. These concepts also have ontological and epistemological implications for the empirical arm of the thesis, explored in the next chapter.

5.1 What is wrong with naïve rationalism?

The previous chapter began to show that the policy response to sickness certification could be considered as being within a ‘naïve rationalist’ framework (Russell et al., 2008). Following Feyerabend (1999) this is characterised as the over-simplistic idea “that policy-making is all about finding and implementing best research evidence, and that the answer to improving policy-making is to identify and overcome barriers to smooth flow or best evidence into practice” (Russell et al., 2008, p.40). These appear laudable aims, and certainly sickness certification policy has used excellent academic papers, such as the seminal review on work and health by Waddell and Burton (2006), to inform its stance. Also, sickness certification policy developments are identifying and overcoming some barriers of evidence into practice. For example, early research into the fit note suggests that people accept its main rationale in principle but that there are practical barriers to surmount such as how SMEs respond to its recommendations (Sparham et al., 2011). The Government is trying to overcome these barriers e.g. it has recently developed an OH advice line specifically for SMEs (NHS Health for Work Adviceline, NHS 2012). This appears to be a positive step forward to reduce rates of sickness certification.

Russell et al. (2008) argued strongly that academic debate on policy-making is constrained by naïve rationalism which remains within the dominant discourse of EBM. The precise composition of EBM is a huge topic in its own right, but an oft-cited definition is by Sackett et al. (1996) “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (p.71). There is a contentious history of debating whether EBM is positivist and reductionist in its narrow definition of what constitutes evidence and has ignored the part of Sackett’s definition
about integrating clinical expertise (Malterud, 1995; Straus and McAlister, 2000) or whether its more modern formulation which highlights interactions between clinical experience, clinical circumstances and research evidence can redeem it in its critics’ eyes (Haynes et al., 2002; Tracy et al., 2003). Certainly, the criticisms of how EBM overlooks the role of the social negotiation of meaning are pertinent to the critique of naïve rationalist policy-making as outlined by Russell et al. (2008). They argue that such policy-making is flawed as it assumes “that policies are driven by facts rather than values and these can be clearly separated; that ‘evidence’ is context-free, can be objectively weighed up and placed unproblematically in a hierarchy; and that policy-making is essentially an exercise in decision science” (Russell et al., 2008, p.40). These criticisms are now unpicked in relation to the policy response to rising sickness certification rates to see if the response can really be characterised as naïvely rationalist, and if so, what might complement this.

Russell et al. (2008) argue that naïve rationalist policy-making and implementation is part of a modernist discourse that equates good practice with finding and implementing the “best” research evidence. May (2006b) pointed out that what constitutes the “best” research evidence is socially constructed. Naïve rationalism assumes that ethical and moral issues faced by policy-makers can be reduced to questions of best evidence whereas the counter argument is that questions about “what should we do?” cannot be reduced to questions about “what do we know?” In terms of sick-listing, there is evidence that work is good for most people (Waddell and Burton, 2006), but it is questionable whether the new Government policies will work without consideration of the conflict GPs feel surrounding their gatekeeping of sick notes (Hussey et al., 2004) and also without considering that patients may rely on sick notes to achieve some kind of state sanctioned legitimate “sick role” (Parsons, 1951; Cohen, 2008) and may simply consider themselves unwell. Chapter four discussed how the Royal College of General Practitioners (RCGP) provides half-day training sessions on work, health and well-being, which include information about the fit note, and practising negotiation and listening skills to reduce conflict in sick-listing consultations. This training complements the knowledge deficit model as it goes beyond simply educating GPs that work is good for people, to encouraging effective communication skills via role-play. Gabbay (2010) noted that GPs already have core communication, clinical and negotiating skills from their general experience, and are capable of using these skills to get more patients back to work. The Government policy guides only mention sick-listing can be challenging but appear to assume that “what should we do?” can indeed be reduced to “what do we know?” as they tell stakeholders work is good for us without considering that doctors may feel sympathy and experience ethical and healthcare dilemmas, if they suspect that a patient’s workplace may maintain or even worsen an ill health condition. Patients may agree that work is generally beneficial, but be frightened of returning in case they cannot cope mentally or physically. Employers may agree that work is good for people and that an employee can successfully return to the workplace when less than one hundred per cent fit, but still be sufficiently worried about the effect on colleagues or business outcomes to want a particular employee not to return.

Russell et al. (2008) showed that naïve rationalist epistemology assumes doing enough research will eradicate ambiguous evidence. The counter argument is that evidence often contains irreducible uncertainties. For example, some chronic pain conditions are difficult to diagnose and as pain can only be measured subjectively, are essentially contestable (Wessely et al., 1999; Halligan et al., 2003; Wainwright et al., 2006). Sickness certification stakeholders have to manage uncertainty, making sick-listing for chronic pain and other MUS challenging. Already we know that GPs managing sick-listing patients with subjective health complaints “missed having hard evidence of illness and loss of function” (Nilsen et al., 2010, p.7). This could be due to medicine’s current valuing of “hard evidence”, whereas chronic pain patients occupy contested space (Eccleston et al., 1997). Foucault discussed how the knowledge we have about medicine
is historically and socially situated, so we can never discover “absolute values of the visible” (Foucault, 1973, p.xii). Ehrlich (2003) reviewed changing understandings of a group of symptoms currently called fibromyalgia, and argued that female sufferers were burnt as witches in the 15th and 16th centuries. This is an extreme example, but illuminates Foucault’s point that “the act of seeing…the gaze” cast over the chronic pain patient privileges society’s current discourses (Foucault, 1973, p.xii).

Russell et al. (2008) explored how naïve rationalist epistemology assumes research evidence is value-free and context-neutral, and that the “evidence into practice” approach is politically neutral. The counter argument is that evidence is inherently value-laden. Conrad and Barker (2010) posited that knowledge about ill health is “not necessarily given by nature but is constructed and developed by claim-makers and interested parties” and contended that we should be critically aware of this when developing, implementing and evaluating policy (Conrad and Barker, 2010, p.67). They argued that the social construction of ill health is often implicated in practices and policies that are implicated in social control. The rhetoric of sick-listing for chronic pain has moved a long way from pain is what the patient says it is (McCaffrey and Beebe, 1989) to “we acknowledge that some of what we are proposing will put more pressure on people to return to work, but we hold that in many cases this would be in their own best interest, not just that of employers and taxpayers” (Black and Frost, 2011, p.5). This shift may be defensible but we need to be conscious of it and explore what lies behind it. Research into sick-listing and the benefits of work is not value-free, yet findings appear to have been translated into Government policy as if they are context-neutral (DWP, 2009: DWP, 2010b: DWP, 2010d).

A final important epistemological assumption of naïve rationalism is that the evidence into practice approach to policy-making is politically neutral. Russell et al. (2008) argued that the evidence-based practice approach is closely aligned with public healthcare management, whose discourse concentrates on efficiency, cost-effectiveness and performance measures. This is relevant as the recent Government initiatives and independently commissioned reviews designed to reduce sick-listing are explicitly couched in cost reduction terms (e.g. DWP, 2008a and 2008b; Black and Frost, 2011) as well as emphasising the health and social benefits of work. Also, most UK GP practices are part of the Quality and Outcomes Framework (QOF), a voluntary incentive scheme, which rewards them financially for how well they care for patients against set indicators e.g. on managing cardiovascular disease and mental health. Better recording of employment status and long-term sickness has recently been proposed as a new QOF topic (NICE, 2010). The QOF approach concords with the modernist discourse of performance measures discussed by Russell et al. (2008) and May (2007) and presupposes a naïve rationalist way of looking at sick-listing, which may not encompass the socially interactive aspects of GP-patient sick-listing consultations. May (2007) argues that medicine is now organised as a corporate endeavour, with performance management that seeks to control outcomes, and assumes that interaction “is part of a business practice that can be engineered” (p.39). If long-term sickness certification performance measurements are adopted, as NICE (2010) has recommended, it will be interesting to see if these acknowledge the kinds of factors within the consultation and external to it which GPs say influence sick-listing decisions. For example, Nilsson and Heath (2003), both GPs, pointed out they take into account their patients’ workplaces when deciding whether to sick-list. They argued that modern work has lost “a socially inclusive solidarity…many labour organisations seem to have lost their way…and now devote more resources to providing counselling for individual workers than in improving terms and conditions for everyone” (p.1057). Nilsson and Heath (2003) argued that doctors will not refuse sick notes until there is better employment rehabilitation. They also claimed that doctors would be less likely to sign people off if there was better access to part-time work, and that people need “control” over their work, although this notion remained unspecified. But their writing shows the concerns of GPs that not all work is good for all patients, and
that sometimes quite intangible considerations – solidarity, non-stigmatising environments and control – are evaluated by GPs when considering whether to sick-list.

There is further evidence that doctors’ decisions about sick-listing are affected by personal views about the context of patients’ working lives. Mowlam et al. (2005) interviewed 24 UK GPs, exploring how they managed sickness absence and assisted patients in returning to work. The researchers found a widely held view that work can be therapeutic both physically and psychologically but that this view “was qualified 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.” (p.1). Also, there is evidence that both patients and GPs are aware of contextual factors which may make work difficult to sustain. Patel et al. 2007 interviewed UK chronic pain patients about their perceived barriers to work and found that simply travelling to work was a major problem which could make them unwell. This showed it may not be work per se which could be seen as harmful but the context surrounding the working day.

Sick-listing performance measures which were based solely on reducing the number and duration of notes would be a blunt instrument indeed as they would not consider any of the views discussed above that doctors have about patients’ quality of work, nor how patients might express their worries about the whole experience of working. Such quantitative measures have not yet been proposed, but chapter four noted that the DWP and RCGP state that the electronic fit note will allow doctors to compare data at individual and practice level, as well as the DWP to extract anonymised data for policy planning. It is hard to object to the latter but the former could be viewed with some concern, if doctors make comparisons without knowing for how long patients have been suffering, what is known about the nature and conditions of the workplace, comorbidities, how well the doctor knows them, and other pertinent issues which may be difficult to quantify. Cost-effectiveness and performance measures have benefits but do not allow much room for the art of medicine (Malterud, 1995) or the “gut feeling” that Stolper et al. (2010) found doctors used as a way of assisting difficult diagnoses, by combining their knowledge of individual patients with clinical experience.

Russell et al. (2008) argue that it is useful to consider the role of rhetoric in policy-making and in research on policy-making, as it highlights the struggle over ideas that occurs in communities. Russell et al. (2008) defined Aristotle’s concept of rhetoric as “the use of persuasion to influence the thought and behaviour of one’s audience” (p.42). This allows us to consider not simply how policy attempts to solve problems, but also how it frames those problems. In this context, rising sickness certification rates have been framed as problematic, caused by lack of knowledge that work is good for us, and also some doctors’ unwillingness to challenge patients’ reticence about returning to work (Wynne-Jones et al. 2010b). This reticence is often framed as either inappropriate, even malingering (Osborne, cited by Robinson, 2010) or simply misguided, and hence open a legitimate target for change (Cohen, 2008). From the literature review in chapter three it seems likely that there are far more complex ways in which to frame rising sickness rates, which are explored in the empirical study reported in chapter seven. It is possible that these are not in fact problematic but rather a response to rising rates of incapacity and that it is an increase in illness and disease that needs tackling as opposed to (or as well as) sickness certification. It is possible to frame sickness certification as a social process which functions to validate sickness experience and can provide needed time off, recovery and successful return to work (Parsons, 1951). Further, even if one accepts the framing of rising sickness certification as problematic, it may be perceived as a social process, involving enactment of chronic pain conditions on the patient’s part, and of the GP role, and from which one cannot remove social norms of sympathy for suffering which affect how certification decisions are made (Hiscock and Ritchie, 2001; Mowlam et al.,2005;
Meershoek et al., 2007). Current policies on sick-listing do little to acknowledge rhetorical processes such as argument and enactment. They overlook the social negotiation of meaning, and issues of knowledge, power and control. Inclusion of these factors may enhance policy-making and aid implementation, as there is evidence from other policy areas that social acceptance and understanding of stakeholders' positions assists policy implementation (Shumway et al., 2003; Falkenmark et al., 2007).

5.2 The Parsonian legacy: the sick role and beyond

Parsons’ sick role (Parsons, 1951) was briefly discussed in chapter three, as some of the sick-listing literature referred to it. Doctors often worry about legitimising chronic pain and other conditions too easily, whereas patients often want to enter the sick-role in order to have respite from societal demands (Hiscock and Ritchie, 2001; Alexanderson and Norlund, 2004; Cohen, 2008). Given that the sick role is explicitly discussed in the sick-listing literature, one might expect it to be foregrounded more in the policy response to rising sickness certification rates. One would not expect policy documents and training materials to use medical sociological language (although ‘the sick role’ is a simple and well-known phrase) but they could certainly highlight more clearly some of the reasons why patients may push for a sick note and why doctors may resist, according to sick role theory. The sick role is pertinent to sickness certification as it recognises the role of norms, values and expectations. However, it uses functionalist assumptions about consensus between doctors and patients, and minimises overt conflict between them. There have also been debates about its applicability to chronic illnesses. How the sick role applies to sickness certification and to chronic pain is now debated.

Parsons’ functionalist sick role has the doctor conferring benefits on the patient (e.g. in the form of legitimised work absence), providing the patient meets the sick role’s two obligations. For Parsons, being well and unwell are social events: if one is unwell and wishes to enter the sick role, there are two rights and two responsibilities. The two rights are that sick people may temporarily withdraw from daily responsibilities at work and home; and that this should occur without castigation as the patient is not held responsible for ill health; indeed they should be offered emotional and practical support. The responsibilities are that the sufferer is obliged to try to get well, and that they must seek help from a competent doctor, complying with treatment. If they enact these, then they are an ideal patient. Parsons also stated that the doctor had complementary duties and rights. The doctor must: act for the patient’s welfare, not out of self-interest; apply appropriate skill and knowledge in the situation; be objective and emotionally detached (Morgan, 1991 explained this means the doctor must not judge the patient or become emotionally involved with them; this may be hard, but is required of Parsons’ ideal doctor). The doctor has the right to examine the patient both physically and in terms of asking personal questions, and has authority over the patient. Parsons considered that the possible tensions arising from the intimate nature of the consultation were ameliorated by the doctor’s responsibility to remain objective and to act in the patient’s best interest.

Parsons (1951) argued that there is a collective dimension to the doctor-patient consultation, as the GP and patient form a dyad in which treatment and recovery are part of larger organisational structures. He maintained that patient, GP and sick role are part of our social system, giving medical care a functional significance for society, as it attempts to safeguard a valuable resource: health. Medicine, for functionalists, manages deviance in the shape of illness and the sick role is an essential part of this.

Morgan (1991) pointed out there is a tension between the doctor’s duty to act in the patient’s best interest and their role in returning individuals to health so that they can be fully functioning members of society. Sickness certification is the first example she cited of this. She showed that back pain is a major reason for being off work and if its cause and severity are hard to assess, so is the legitimacy of access to the sick role. Then the doctor
must decide whether to prioritise the patient's interest or society's, if these two do not accord. This tension makes GPs uncomfortable and many express unease at being both the patient's advocate and the gatekeeper to sickness benefits in the broadest sense, meaning both the incapacity benefit system and all the societal benefits of being certified off sick by a doctor (Hiscock and Ritchie, 2001; Hussey et al., 2004; Cohen, 2008).

Armstrong (1989) suggested that Parsons' sick role (1951) only makes sense if we consider the four tenets in relation to controlling the social meaning of illness. Armstrong (1989) emphasised that being temporarily excused one's normal social role by a doctor exemplifies the power of medicine to maintain social control, as working is a central societal norm. Parsons theorised that the GP's role is to legitimate the sick role, and also to provide the spur to leave it (Seidman, 1998). Armstrong (1989) suggested this posits the GP as the powerful one, although the patient is still expected to get better and still might be judged if they are not able to do so. He pointed out that personal responsibility for health is a political issue which assumes people are able to get themselves well. With chronic pain and many other types of ill health, it can be argued that this is not possible, yet sufferers who "fail" to get better are judged (Eccleston et al., 1997; McParland et al., 2011). Glenton (2003) argued that the sick role exerts a strong pressure on chronic back pain sufferers, as they, their doctors and society still expect its elements to apply to chronic conditions, even when there is no clear diagnosis (perhaps especially when, to make up for this lack in some way).

Some sick-listing literature discusses how the sick role influences whether or not a sick note is given. For example, Hiscock and Ritchie (2001) and Cohen (2008) showed how patients actively seek sick notes in order to justify being off work. Glenton (2003) asserted that the pressure of the sick role serves to foster the dependency of chronic back pain patients on doctors, which is unhelpful. Hiscock and Ritchie (2001) and Cohen (2008) also showed that GPs like to give notes in order to legitimise their role, particularly if they have been unable to successfully treat the patient's ill health complaint. In this way, the sick role makes doctors dependent on the ability to legitimate illness in order to feel comfortable with their own role as doctor. The Government's attempts to change GPs' sickness certification habits can be seen as a response to the notion that GPs are no longer providing enough Parsonian "spur" to leave the sick role, as well as allowing patients to enter it too easily, but the mutual dependency by both doctors and patients on the sick role, outlined above, means that behaviour change is likely to be difficult to achieve.

Gerhardt (1987) reported how Parsons’s sick role concept has been criticised for excluding chronic illness and also the variability of normative experience. Yet Parsons himself (1975 and 1978) discussed how the sick role could be adapted to chronic conditions, as one could approximate rather than entirely accomplish the goal of recovery, and could be permanently excluded from some duties rather than temporarily from all. For example, one could permanently be excused from heavy lifting at work rather than temporarily be signed off sick. Parsons also acknowledged that in chronic cases, patients should still try to return to functioning, but that the physical reality of their condition may prevent or limit such return. Similarly, Bury (1982) noted that whereas adaptation as part of the sick role is linked to views of disability as a stable entity, many forms of disablement involve fluctuating conditions and uncertainty and “a chronically ill person can make adoptions to his [sic] lifestyle and still have access to periods of classic sick-role behaviour when such events as surgical intervention or sudden exacerbation of symptoms occur” (Bury, 1982, p.168). In other words, the sick role can apply in cycles to chronic illness, as the illness fluctuates.

Chronic pain patients may never recover but may adapt to a different way of life, e.g. via cognitive behavioural therapy (Eccleston et al., 2009) and may never work full-time but
manage part-time, depending on their condition, finances and personal circumstances. The new fit note is designed to get everyone back to full-time work eventually. This may not be in the patient’s best interest. The Government argues that it is encouraging more appropriate sickness certification, so only those for whom full-time work is appropriate should go back to it (although the research behind the fit note says that is nearly all of us (Black, 2008; Black and Frost, 2011). However, Parsons’ 1975 modification to the sick role acknowledges that some people may never fully leave it, which the Government admits, but argues applies to very few people (DWP 2008a and 2008b; DWP, 2009, DWP 2010a; DWP 2010d).

Researchers have criticised Parsons (1951) for assuming that we all want to return to health, yet failing to predict or explain differences in illness behaviour between individuals and different groups e.g. men and women, social class and ethnic groups (Wainwright, 2008). Young (2004) argued that norms and values attributed to the entitlements and duties of the sick role vary between social sets, reflecting differences in socialisation. Indeed, there is some evidence, presented in chapter three, that gender of patient and practitioner does impact upon sickness certification decisions (Hiscock and Ritchie, 2001: Shiels and Gabbay, 2006).

Wainwright (2008) highlighted that Parsons is criticised for assuming the patient and the GP work together to normalise the patient’s health whereas Friedson (1960) showed that doctor-patient relationships are often filled with conflict and negotiation. Parsons does not discuss the conflict many others maintain is part of the GP-patient relationship. However, sickness certification research shows that the sick role becomes an area of conflict, both within GPs’ views of their own practice (they are often aware that sanctioning the sick role is not the best way to help some patients but do this anyway in lieu of anything else to offer) and between the doctor and the patient. Coole et al. (2010b) also showed that patients feel intra-personal conflict over the sick role, as they may want reparative time but also worry about how others will view them as well as the practical aspects of being off work.

Wainwright (2008) argued that contested diagnoses such as fibromyalgia (Wessely and Hotopf, 1999) highlight the social negotiation that occurs in sickness certification consultations as the patient’s accounts of illness may prevail over any technical exercise based on evidence of pathology, and may especially prevail if such evidence is lacking. Chew and May (1997) found GPs were asked by chronic lower back pain sufferers (without definable cause) to validate their entry to the sick role and that doctors found this problematic as they felt “forced to collude with the patient's definition of ill health” (p.461). Greco (1998)’s Foucauldian perspective discussed how the contentious term ‘psychosomatic’ can be approached as “a space, a multiple and contradictory space...that emerge[s] when a domain of action or behaviour, illness in this case, has lost its customary familiarity, and become uncertain, as a result of social, economic or political processes” (p.5). Chronic pain patients, like other patients with MUS, tend to want a diagnosis; the chronic pain literature consistently reports patients’ desire to be believed (Eccleston et al., 1997; Soderberg et al., 1999) and to receive a diagnosis that points to a physical rather than psychological cause (Reid et al., 1991; Wainwright et al., 2006). In addition, Crombez et al. (2009) showed how the term “somatisation” is poorly, even dangerously, constructed in empirical studies of pain, and that this can have clinical implications in terms of physical causes of pain being overlooked. Perhaps patients are correct to be wary of “somatisation” and “psychosomatic” explanations of their pain.

Eccleston et al. (1997) showed that chronic pain is often seen as senseless by patients, and that such senselessness “offers a fundamental threat to meaning and to identity creating the urge and desire for meaning to be found” (p.700). Patients often wanted a diagnosis at all costs, as this was part of their search for meaning and of their
ability to narrate and enact their condition (Kleinman, 1988); if no diagnosis was forthcoming, both meaning and narration were questioned. Being given a sick note may be part of the creation of meaning for chronic pain patients. If a diagnosis has been given, the sick note allows the patient to withdraw from work without blame (Parsons, 1951).

Eccleston et al. (1997) found that chronic pain patients are often blamed for their condition (McParland et al., 2011, still reported this finding, fourteen years later). Patients were stigmatised for being difficult, especially if pushing for a diagnosis. Eccleston et al. (1997) chose a very poignant citation from Kleinman (1988) which resonated strongly with patients’ desires to be legitimated via sickness certification “If there is a single experience shared by virtually all chronic pain patients, it is that at some point those around them – chiefly practitioners, but also at times family members – come to question the authenticity of the patient's experience of pain” (p.57). Analysis of the qualitative data collected for this thesis’s first study strongly concurs with Kleinman’s words; this point is discussed in chapter seven.

Glenton (2003) explored how chronic back pain sufferers strive for the sick role, examining data from online discussions in Norway as well as from in-depth interviews with back pain sufferers. Both sources showed participants fearing that the reality of their pain was being questioned, and that delegitimation and stigmatisation occurred as a result of sufferers’ inability to attain the sick role. Participants wanted proof that they were sick, and medical diagnoses, partly to access sickness benefits but just as importantly to avoid real or presumed accusations of malingering. Some patients felt ambivalent about getting sick notes, as they wanted the certificate to access benefits and feel legitimised but also felt that being certified as sick was a way for GPs to write them off and not have to bother trying to manage their condition. These feelings appeared to affect patients’ views of GP-patient relationships. Chapter seven discusses empirical results from study one showing patients’ ambivalent feelings about getting a sick note affected social negotiation processes within sick-listing consultations.

The classic sick role formulation is perhaps too focused on consensus to account for the high levels of conflict so many sick-listing studies report (e.g. Alexanderson and Norlund, 2004; Engblom et al., 2010, see chapter three for many more), particularly for MUS of which chronic pain conditions are a good exemplar. Indeed, Wainwright (2008) and Hardey (1999) argued that Parsonian GP authority has been eroded by patient centred medicine and expert patient programmes. Wainwright (2008) maintained that although patients still need formal sick notes to access various types of sick pay or benefits, obligations to comply with GP treatment have been weakened by modern notions of mutuality and concordance (Stimson, 1974). This power shift enables patient accounts of illness to be accorded more importance in sick-listing processes and is another reason why GPs may find it difficult to respond to Government policies designed to reduce sickness certification.

In summary, the literature concerning what it is to be a chronic pain patient shows that an important part of the patient experience centres around fears of not being believed, which studies suggest is linked to the desire for a sick note to legitimise entry to the sick role, and the often protracted search for a clear diagnosis or at least some form of narrative that invests the experience of pain with meaning. It is unlikely that patients’ sickness certification behaviour will be changed unless these complex issues are addressed. Both GPs and patients have strong feelings about the sick role, which are often in conflict and can be challenging for each party to manage within the consultation. It also appears that an individual, whether patient or GP, may also feel ambivalent about the sick role as sanctioned by sickness certification, on the one hand recognising its value in granting an opportunity to recuperate, but on the other hand worrying about how to
provide the spur to leave it (GP) or what it symbolises about the patient’s worth in a society that places a high value on work performance (Wainwright, 2008).

Government websites and literature on work, health and well-being make very little of how modern GP-patient power struggles and differentials may impact upon sickness certification (DWP, 2010e). Both Parsons’ original formulation of the sick role and criticisms of it are useful when considering the problematic elements of sickness certification for chronic pain patients. Yet recent policy initiatives largely overlook these insights regarding normative influences on sickness certification and the tensions they brings to the doctor-patient relationship. For example, policy-makers have been reluctant to acknowledge that patients might want a sick note, even when the doctor is sure they do not need one for medical reasons, because they prefer the social identity of the sick role to that of unemployment (Barnes et al., 2008). There may be benefits in enabling doctors to become more aware of the psychological and social reasons for patients seeking sickness certification and also of the role played by their own norms of sympathy and compassion in influencing their sick-listing decisions. This awareness raising might not reduce sick-listing (a doctor might decide to sick-list to allow someone to avoid being categorised as unemployed) but making stakeholders more aware of reasons for sick-listing, and perhaps allowing more open discussion of reasons, might facilitate broader change in the long run (e.g. reduce stigma over unemployment if jobs are hard to get).

5.3 Stigma

Parsons points to the functions of normative regulation, but this can entail the use of stigma as an informal method of social control. Much research suggests that stigma is a key part of the suffering endured by chronic pain patients. There is also some research into return to work processes for chronic pain patients, which discusses stigma and its effect on sick-listing. Additionally, it was an emergent theme in data from studies one and two, discussed in chapters seven and nine. For all these reasons, it would be useful if sickness certification policy-makers considered stigma.

Goffman (1968) defined stigma as a social response to deviance, a way for ‘normal’ members of society to categorise and label those who have transgressed social norms. Stigma confers a spoiled identity on recipients, who may internalise it and feel the lack of respect they are accorded is deserved. However, Goffman (1968) contended that stigmatised individuals are not passive recipients but try to manage stigma by minimising its significance (termed ‘covering’) or concealing it (‘passing’). Goffman argued that some stigmatised individuals may take a more confrontational approach and join or create a group of similarly affected people, who then lobby for acceptance. Alternatively, they may adopt normative beliefs about what comprises good personal adjustment, by trying to adopt identities which are acceptable to ‘normals’.

There is an established literature showing chronic pain patients often feel stigmatised as malingerers and do adopt covering and passing strategies (Reid et al., 1991; Bendelow and Williams, 1995; Jackson, 2000; Chew-Graham and May, 1999; Soderberg et al. 1999). They are being urged to accept the normative identity of ‘worker’ but this may not be in their best interests, if they accept work which may exacerbate their condition (e.g. jobs with poor working conditions). Wainwright et al. (2012) pointed out that exclusion from work could be an even more damning fate than harmful work. However, they also showed that if patients and GPs were tacitly or explicitly aware that patients’ work was of low status and poorly paid, then patients were unwilling to take on such work and GPs were unwilling to persuade them. This is discussed in chapter seven.

Goffman (1968) argues that stigma often compels the ‘deviant’ individual to try to conform to social norms, but often this only leads to ‘phantom acceptance’ by the ‘normals’, i.e. the problem of deviance may be reduced for the ‘normal’, but the ‘deviant’ is
not fully accepted back into the ‘normal’ group. This may have adverse consequences for the ‘deviant’ who is expected to “act so as to imply neither that his [sic] burden is heavy nor that his bearing has made him different from us” (p.147). Chapters seven and nine discuss this, as some chronic pain patients try to work full-time to conform, even though this causes significant suffering, but the ‘normals’ still do not fully accept them. Goffman (1968) also discusses how family and friends try to manage individuals’ stigma by assisting with passing and covering, a process he termed ‘courtesy stigma’; this issue emerged in study one, and is discussed in chapter seven.

Patel et al., (2007) undertook a qualitative explanation of the barriers to work for UK patients with chronic pain. This was the first qualitative study of long-term unemployed benefit recipients suffering from chronic pain. Study participants said that a visual aid such as a walking stick made (previous) employers more likely to believe that their employees' pain existed. These patients appeared to feel stigmatised by having an ill health condition which was not always visible but still caused work absence, as colleagues and bosses judged them negatively for taking time off. Patients said they feared letting employers down; the researchers asserted that patients conceptualised such fears in terms of threats to their own identities and self-images as workers. One participant stressed ‘I don’t trust myself to commit myself to anybody else work-wise anymore, for fear of letting them down.’ (Patel et al., 2007, p.837). As the researchers pointed out, such fears are very difficult for employment staff to address. Data analysed in study one show that the same is true for GPs in sickness certification negotiations. Patients like those in the Patel et al. (2007) study, who feel the need for visible symbols of their ill health, and also may want to work but feel genuinely unable to, often negotiate hard for sick notes, as these pieces of paper are not merely representative of the sick role but tangible proof that it has been entered (Parsons, 1951). Although the participants in the study by Patel et al. (2007) were well aware of the potential psychological and financial benefits of work, their “spoiled identities” (Goffman, 1968) were greatly reducing their chances of successful return to work. In this way, as shown by Bury (1982) stigma affects an individual’s capacity to mobilise the cognitive and practical resources available to them. Everyday life has to be navigated differently and the individual has to learn different explanatory systems, as their chronic condition has disrupted their normal ones.

Physical limitations also affect how people return to work or otherwise and people who struggle in this regard are stigmatised even if such limitations are no fault of their own. Goffman (1968) makes this point when he argues “mere desire to abide by the norm - mere good will – is not enough – for in many cases the individual has no immediate control over his level of sustaining the norm” (pp.952-3.) This is a similar point to Parsons’ that physical limitations must be taken into account when deciding when and how to leave the sick role, particularly for chronic conditions. This was shown by Patel et al. (2007) as participants averred that it was chronic pain that was the main problem “from which most other barriers stem” (p.833) and that the unpredictability of pain was a major barrier to work. Participants also felt that travelling to work was a problem, as they expended much effort in regulating their pain which travelling then disrupted. Participants had low-paid, low skilled jobs, which did not give much opportunity for flexible working patterns such as changing hours and duties, promoted as ways back to work by the fit note. Government rhetoric acknowledges that some people are simply unable to work at all or part-time, but the bar is set very high e.g. in ESA tests, one of the criteria for such acceptance is terminal illness predicted to cause death within 6 months (DWP, 2010b). GPs tend to err on the side of caution when assessing functionally, as they do not wish to harm their patients (Norrmen et al., 2008) - again, when there is lack of observable pathology, and patients’ own accounts and enactments are key, there is much more room for doubt about whether or not to issue a sick note than is acknowledged in Government materials on work, health and well-being.
Williams’ (1987) account of Goffman’s concept of stigma posited that some illnesses and diseases are ontologically offensive as they disrupt different types of social intercourse. Empirical work with sufferers of epilepsy showed how they are stigmatised. As chronic pain patients are also stigmatised, it is pertinent to consider if those who do not work, and who we know engender scorn (McParland et al., 2011), are similarly viewed as offensive, as they disrupt the social intercourse of work. The results chapters of both empirical studies consider this point. Acknowledgement of these issues around stigma is missing from Government rhetoric, policy and training materials that claim work is good for us. Policy alone cannot change stigmatisation, but could recognise it as an influence which may achieve the objective of pushing people back to work (albeit at a high price for some of them) but which may also hinder return to work for others, as it spoils their social identity. Chapter nine discusses how stigma alters people’s sense of self, in ways that can make successful return to work very difficult.

5.4 Foucault and the discourse of health

When addressing sick-listing, and whether or not people return to work, we are essentially exploring: their illness behaviour, i.e. how they behave in response to their experience of symptoms; how their input into the capability decision is shaped by their interaction with their doctor and employer; and how these interactions are influenced by what is considered socially (un)acceptable. The writings of Michel Foucault offer valuable insights into these processes, as he considers how knowledge and power are bound up together in discursive formations i.e. in structures and their inherent ideas and knowledge.

Foucault highlights the way that micro-interactions are affected by medical knowledge and the conflict this can bring to consultations. This is useful, as Parsons largely omits the notion of conflict from the GP-patient relationship. This omission is ironic given that sickness certification research showed that the sick-role often develops into an arena for conflict between the doctor and the patient. The sick role also becomes an area of intrapersonal conflict as each party struggles with reconciling reparative time off with the emotional and practical difficulties of being on sick leave. For Parsons, a function of medicine is to restore social order, but perhaps re-establishing this is not in chronic pain patients’ best interests i.e. should they necessarily obey the doctor if they think their personal knowledge of their workplace, their body and their pain trumps that of the doctor? This notion of social control is overt in some of the policy documents about sick-listing (e.g. see Black and Frost’s (2011) comment that “we acknowledge that some of what we are proposing will put more pressure on people to return to work but we hold that in many cases this would be in their own best interest, not just that of employers and taxpayers” (p.5) and links with Foucault’s writings concerning how knowledge is bound up with the exercise of power (Foucault, 1973, 1976, 1980). For Foucault, power is situated at an inter-personal level, its exercise occurring as a result of micro-interactions between people (in this case, between the doctor and patient in consultations). Foucault theorised that power is an integral quality of social relations, including knowledge or economic relations, so it is brought to bear in everyday situations in which equality and inequality are constantly being restructured and reordered (see also the concept of the negotiated order of the clinic, from Strauss et al., 1963, discussed later in the thesis). According to Foucault, power derives from “below”, i.e. from micro-interactions that are constitutive of broader social power sites:

“Power comes from below; that is, there is no binary and all-encompassing opposition between rulers and ruled at the root of power relations, and serving as a matrix - no such duality extending from the top down and reacting on more and more limited groups to the very depths of the social body. One must suppose rather that the manifold relationships of force that take shape and come into play in the machinery of production, in families, limited groups, and institutions, are the basis for wide-ranging effects of cleavage that run through the social body as a whole. These then form a general line of force that traverses...
the local oppositions and links them together; to be sure they also bring about redistributions, re-alignments, homogenizations, serial arrangements, and convergences of the force relations. Major dominations are the hegemonic effects that are sustained by all these confrontations”. (Foucault, 1976, p.94.)

Foucault is interested in the way that power manifests itself at the micro level of personal interaction although he acknowledges that protagonists are embedded in discursive formations, based in particular situations and organisations (in the case of sick-listing, doctors and patients are embedded within the NHS, the workplace and the benefits system, employers within the workplace and benefits/legal system). Foucault argued that power is exercised consciously at the level of micro-interactions but that the processes which make its workings patterned, hence perceptible at a macro level, come about due to mostly unconscious accretions of the micro-interactions. This is what is meant when he argues that “power relations are both intentional and non-subjective” (ibid). For example, in sick-listing, the doctor sees different patients about sick-listing and over time develops strategies to manage them, or the same doctor and the same patient meet severally over sick-listing, and each set of micro-interactions congeals into a set of strategies protagonists can use, embedded in their larger structural constraints (i.e. culturally sedimented values about how a doctor or patient should be, how the NHS affects them, norms about who should or should not receive benefits).

Foucault posited that because power is manifest at the micro level of inter-personal interaction, it can be challenged by personal acts of resistance. For example, doctors can refuse to send patients back to work in order to meet the imperatives of the welfare system, if the doctor believes that a patient is better served by being sick-listed; patients can refuse to acknowledge the putative primacy of biomedical knowledge, by asserting the privilege of subjectivity and of “pain is what the patient says it is” (Meinhart and McCaffery, 1983) rather than pain is what the doctor can assess the patient has. Even if the doctor agrees the patient’s account is vital, patients can assert that “pain is what the patient says it is” rather than agreeing with social norms that chronic pain patients whose conditions are invisible or fluctuate should be judged harshly (Jackson, 1992, 2005). It is about one doctor and one patient and their micro-interaction in the moment of the consultation, but they are constrained by the discursive formation in which they operate. They can challenge it, and have opportunities to transform it slowly over time, but are still working within discourses, although these discourses may allow more or less freedom to an individual.

Most obviously, the patient and doctor are constrained by the doctor’s knowledge, as both are operating within discourse and having their actions constituted by discourse. When biomedicine became dominant, patients’ bodies could be observed and objectified in the location of disease at an anatomical level. Foucault (1973) showed how the development of the clinic as a means of training doctors emphasised observation and how this practice is an expression of medical power. Doctors have physical authority over patients as they observe and examine, as well as intellectual power, as it seems that doctors know about patients’ bodies better than patients do. Foucault (1977) argued that reality does not exist in absolute terms outside our perception of it, so medicine is socially situated and creates its own objects and reality. The medical “gaze” is based upon the observation of physical pathology and the assumption that the absence of observable pathology is synonymous with the absence of disease. As such it is likely to judge chronic pain patients harshly, by concluding that in the absence of physical pathology they are fit for work. Of course, doctors do not have to restrict themselves to the traditional medical gaze when they assess chronic pain patients’ capability for work, they may invoke the newer biopsychosocial model, or other more subjective methods of decision-making, but this departure from the biomedical model often leaves doctors feeling uncomfortable with the subjectivity of pain and uncertainty about the capability decision (Nilsen et al., 2011).
This is not least because in the absence of a physical ‘cure’ they are often forced to rely on moral exhortation to encourage the patient to get well or adapt (Bury, 1982; Eccleston et al., 1997).

Although the medical “gaze” is implicated in the exercise of social control, Foucault also argued it is creative, as it constructs new ways of thinking about the body, i.e. that it is discrete and amenable to analysis, enabling individuality (Foucault, 1973, 1977). Armstrong (1989) suggested that as medicine began to consider psychosocial elements to disease and illness, the body consequentially became a socially as well as physically discrete entity. In this way, medicine’s practice creates then reinforces notions of the patient’s subjectivity. Patients internalise the way in which the medical gaze (including the newer biopsychosocial model) defines them and this causes them to recognise themselves in a particular way. In the context of sick-listing, patients may be defined as clearly unable to return to work, which may or may not be problematic for how they recognise themselves. Other patients may be defined as clearly able to return to work, which again, may or may not be problematic for how they perceive themselves. And some patients will be in a grey area, in which the medical gaze cannot definitely define them as one thing or the other, but may still be subject to norms of sympathy or of wanting to pressurise them back to work, perhaps as it is genuinely believed it is best for them, or out of desire to comply with current notions of good medical practice. Patients may internalise these identities and feel, for example, that they lack stoicism, if they are worried about returning to work, but feel pressurised to do so.

If medicine does indeed create and reinforce patients’ notions of their own selves, then it could be seen as either invading people’s privacy, in medicalising everyday life, or actually creating identity by examining private arenas, and certainly Foucault argued for this creative aspect of medical discourse as well as its more repressive elements (Foucault, 1973, 1977). However, Armstrong (1983) also argued that whilst such practice may appear humane in its willingness to consider protagonists’ subjectivity, it still subtly controls patients, as they are encouraged to bring their psychosocial needs to the consultation, almost in confession, perpetuating unequal power relations with the doctor. Pink et al. (2007) suggested that society expects GPs to be both physician and priest, but did not discuss the power that inheres in a ‘confessional’ relationship. In sick-listing terms, the patient is constructed as needing to be an active citizen who ought to be able to get better or at least to play an active part in making the most of where they are. In the micro-interaction with the doctor, they must “confess” or at least unfold their narrative (Foucault, 1976) which requires bravery, articulacy and perhaps some acceptance of how things are, and willingness to ‘submit to intimate surveillance under the guise of progressive humanism” (Armstrong, 1987, p.71). The doctor must tussle with objectifying the body as a site for expert dissection as well as mapping the patient’s account and enactment of pain onto this.

Foucault is not interested in the “truth” of the consultation but in why society is so keen to get at a clear answer and the historical situation that privileges “truth”:

“Why, in fact are we attached to the truth? Why the truth rather than lies? Why the truth rather than myth? Why the truth rather than illusion? And I think that, instead of trying to find out what truth, as opposed to error, is, it might be more interesting to take up the problem posed by Nietzsche: how is it that, in our societies, “the truth” has been given this value, thus placing us absolutely under its thrall?” (Foucault, 1988, p.107)

Why are we so keen to find out the “truth” of if the patient is capable or not, if their level of suffering warrants acceptable pain-related work absence? It may be that the issues are so complex, to do with the patients’ and doctors’ feelings about the sick role, about stigma, about their identity as a humane doctor or a good person, that it is almost a
red herring to focus on the truth or otherwise of whether or not someone deserves to be sick-listed. There are practical reasons for doing so – expenditure on sick pay, and on benefits, for companies and society, and to avoid all the psychological and financial ills of being off work. Foucault might say these are simply the historical situation that allows the truth of the capability decision to be searched for. To reiterate a key point of his, knowledge cannot be separated from power. Foucault’s relativist approach to knowledge is helpful in that it makes one take stock of the political situation which has produced the policy response to rising sickness certification rates. It is also useful as it makes more explicit the manner in which knowledge and power are intertwined.

Foucault does not explain why, if knowledge and power are inseparable, we should accept his truth claims. Also, Foucault asks why we should privilege reason over myth. The answer is that rationality offers us some solutions to practical problems (Wainwright, 1996). We can accept that knowledge and power are intertwined but it does not follow that one discourse is no better than another. Different truth claims can be tested out. In the domain of sick-listing, Foucauldian relativism would question whether the medical gaze, (or even the biopsychosocial gaze), could uncover the ‘truth’ about someone’s capacity for work, but it would surely be a mistake to assume that evidence of physical pathology is incidental to this question, or that biomedical knowledge offers no better grasp of reality than alternative discourses. Roy Porter (1997) offers the observation that a surgeon operating under William Harvey’s theory of the circulation of blood would kill fewer patients than one following the Galenic theory. Similarly, application of the biomedical gaze can bring benefits to the chronic pain patient that should not be trivialised or downplayed.

Foucault’s point is that despite the curative potency of biomedicine, it offers a particular way of seeing, which influences the way in which problems are constructed and putative solutions arrived at. These constructions are not neutral in terms of the exercise of power. Moreover, the value ascribed to biomedical science is such that its authority can extend beyond its range of application. Thus, sick-listing decisions may be based on social and cultural factors that lie well beyond the biomedical domain, but the doctor’s status as a practitioner of evidence-based medicine can lend his or her decisions an authority that might not otherwise be acknowledged.

Foucault’s micro-interactional conception of power is useful as it highlights how interpersonal relationships are imbued with power, but problematic as it underplays how power is exercised consciously at a structural level. For example, despite what transpires in the consultation room between doctor and patient, the behaviour of both will be constrained and driven by policies that are consciously planned (such as those designed to reduce the level of benefits). Foucault’s micro-analytical approach offers little insight into the exercise of power at the macro level. Many sociologists have also criticised the lack of agency in Foucault (e.g. see Poster, 1984 and Giddens, 1991). He theorises that we are inevitably constituted by discourse, but Poster and Giddens point out that people can and often do argue back against discourse, that they are capable of examining what is being said to and about them and comparing it to their lived experience. For Foucault, resistance of this kind simply comprises the adoption of an oppositional discourse rather than the dawning of self-conscious awareness of one’s interests. However, if the medical discourse does not fit their embodied experience of pain, many patients will articulate this, and such processes of examination and action may enable the response to chronic pain to be changed over time. While this process of change can be dismissed as simply replacing one discourse with another, it would be a mistake to overlook the critical and creative role of agency within it. The criticisms that Foucault tends to diminish the role of agency in reproducing and transforming discourse at both the micro and macro levels leads us into consideration of the work of Bourdieu, and more specifically into
consideration of the extent to which his concept of habitus provides a more satisfactory answer to the structure-agency problem.

5.5 Habitus and social reproduction

The structure-agency problem is fundamental to sickness certification for chronic pain patients, as we need to consider the choices protagonists have and how these are constrained. We have seen how Foucault minimises agency in his focus on micro-interactions being influenced by discursive formations. By creating a meso-level concept which mediates between micro-interactions and macro structures, Bourdieu recognises the processes of social reproduction, and how we are neither wholly constituted by structure nor have complete free will, but rather our ideas and behaviour are continually constituted by structures which we also can influence. Bourdieu defined habitus as basic, deeply interiorized master-patterns: "a system of durable, transposable dispositions, structured structures predisposed to function as structuring structures" (Bourdieu, 1977, p.72). In other words, habitus comprises dispositions to behave in certain ways, in certain situations (Fries, 2009). It is both individual and collective, as it explains individual behaviour by analysing the interplay of personal agency with the influence of social structures such as markets, social classes and organisations. Habitus can belong to an individual, with all the meanings that are important to someone's different life roles, and also be strongly group-based e.g. Bourdieu argued that there is a habitus of being a school child, and a school teacher, that affects how individuals behave at school (Bourdieu, 1984). Bourdieu tried to penetrate beneath individual consciousness and intersubjective meanings such as beliefs and values, and arrive at the social source of these (Seidman, 1998). However, Bourdieu believed we can also influence social structures, and be intuitive and innovative. He posited that habitus is a product of social structures but also generates them, encompassing a dialectical relationship between structure and agency. Our agency can change structure as well as being influenced by it: if we flick food from a fork at a sibling, but know we are not supposed to use the fork thus, we have changed the fork's function as well as suffering constraints to our agency as we are aware of our deviance. Bourdieu (1990) theorised that "Only in imaginary experience (in the folk tale, for example) which neutralises the sense of social realities, does the social world take the form of a universe of possibles equally possible for any possible subject" (p.117). In other words, power relations constrain choice although there are choices to be made; habitus mediates between macro and micro levels of determining factors.

Bourdieu's ontology also divided the social world into separate but interconnected cultural contexts, termed “fields”. These have their own sets of cultural resources or capital (Bourdieu, 1986). Some fields are pertinent to the social processes of negotiating sickness certification. Cultural capital comprises knowledge and skills, and also their material representations such as qualification certificates. In chapter seven, findings from the empirical arm of the thesis are reported which show how GPs use cultural capital to support their professional role when in a consultation. Related to this is social capital, in which Bourdieu (1985) showed how people try to accrue social power via the construction of their social relationships. These forms of capital become embedded within habitus (Bourdieu, 2000).

From Bourdieu’s theoretical position, one can see how both GPs and patients may embody habitus, as individuals, and as members of different work and social groups, and that these types of habitus may collide and make it difficult to act on rational knowledge, even supposing such clarity is available within the sick-listing consultation. GPs' habitus is generally one of high cultural capital (Bourdieu 1986), and sickness certification can be seen to diminish that capital. Patient habitus involves the need to be seen as a credible sufferer by one's doctor and social network (Reid et al., 1991; Glenton, 2003). Being believed may be enough; patient habitus may involve the desire to be perceived as stoical
and also as normal, leading patients to try to minimise the appearance of their suffering to others (Monsivais and Engebretson, 2012). However, it may include getting a sick note, to reduce stigma and increase legitimacy, even if that patient may actually do better working than being off sick. Both patients and GPs also see the Government as having its own habitus, which can be defined as helpful to them but more often is seen as in conflict with their goals. These issues emerged in study one, discussed in chapter seven.

Some research into sick-listing discusses the role of habitus. For example, Hiscock and Ritchie (2001)’s review of GP and patient views on sickness certification found that patients suffering from all ill health conditions, including musculoskeletal disorders, were more likely to take sick leave if there was little disapproval from fellow workers and managers i.e. if there was a certain employee-employer habitus in a workplace which did not stigmatise absence. Virtanen et al. (2000) explicitly considered how habitus and its attendant cultural and social capital properties may influence workers’ sick leave behaviour. Virtanen et al. (2000) used the cultural and social capital inherent in three different locations of the same company in Finland to help to explain noted differences in workers’ sickness absence behaviour between these locations. This was a sophisticated study which controlled for geographical and demographic variables at the sites. The researchers analysed three types of data: sick notes which listed diagnosis and duration of sick leave, stakeholder interviews and postal questionnaire responses. Virtanen et al. (2000) did not stratify their results by ill health condition, but it is known that Scandinavian workers have similar reasons for sick leave as those in the UK (Arrelov et al., 2003; Bevan et al., 2009), so it can be assumed that a large proportion of these Finnish workers suffered from musculoskeletal disorders. Virtanen et al. (2000) found that workers responded to ill health by taking sick leave if such action accorded with local social norms, as workers were aware that they would be under scrutiny for having been absent. The researchers showed that these social norms were influenced by local cultural capital, and that the more education workers in a locality had had, the less they took sick leave. Virtanen et al. (2000) suggested that this is because those with fewer formal qualifications see their body as their prime route to receiving money via labour, hence have to protect it more quickly from perceived and actual physical harm, which is usually seen to be caused by work. This interpretation could be seen as paternalistic, yet the notion of local habitus influencing sick leave is worth exploring, as other sources also report geographical variation or variation between different companies’ sectors, even if they are physically close, suggesting group worker norms and possibly social capital may also influence sick leave decisions (CBI, 2009). Vaananen et al. (2008) also reported that group absence norms affected sickness absence behaviour. They surveyed nearly twenty thousand Finnish workers and multilevel Poisson regression found that the more tolerant the group absence norms (at both individual and cross-level) and the lower the group cohesion (at the individual level), the more an individual’s sickness absence behaviour was influenced by their attitude to work attendance.

Virtanen et al. (2000) also found that doctors were affected by communities’ social norms, adjusting their sick-listing according to the local sickness absence norms. Habitus thus gives a context for negotiation in GP-patient consultations. Parsons et al. (2007) systematically reviewed the effect of patients’ and primary care practitioners’ beliefs and expectations about chronic musculoskeletal pain on the process of care, including sickness certification. One of their conclusions was that to tackle its challenges, changes would have to occur not just at individual level, but at organisational and systemic level. We need to investigate what the GP and chronic pain patient habitus is composed of, what choices people feel they have, and how they feel constrained, if we are to tackle the challenges of the sick-listing process.
Conclusion

Drawing the strands of the chapter together, I have argued that the Government has largely adopted a naïve rationalist model of policy-making and implementation in its attempts to reduce sickness certification. The Government appears to assume that by its dissemination of knowledge that work is good for us, with marginal acknowledgment of the potential for conflict, and minimal suggestions of how this might be managed, stakeholders will be able to apply this knowledge to sick-listing consultations in a manner which will change sickness certification processes. However, negotiations can be problematic for stakeholders when patients have chronic conditions and either do not recover, or have recurring symptoms. An absence of observable pathology for many chronic pain patients evokes the theme of malingering, which is very difficult to manage, especially for those who feel they really cannot work. Therefore, despite the evidence that good work is important for health and well-being, it is especially difficult for GPs and chronic pain patients to negotiate the provision of sick notes. Sociological concepts such as habitus, the sick role and stigma are useful notions when considering how the rhetoric that work is good for us is enacted in GP-patient consultations. Foucauldian arguments that we are constrained by discourse, are useful to consider: the medical gaze constructs the truth according to a particular set of rules, so for example, absence of physical pathology is taken to mean no health problem, therefore return to work is appropriate. Adding the psychosocial arm to the biomedical creates additional ways of seeing the problem and different criteria for arriving at the ‘truth’ but still lies within a historically specific way of seeing. We need to be aware that sick-listing is not about doing something wholly scientific, but entails moral, social and political discourses, which constrain protagonists. Bourdieu's stance that we can be influenced by and influence structure, also needs consideration, if we are to study issues of knowledge, power and social control, crucial to a better understanding of the challenges of sick-listing. We need to study the social negotiation of meaning, in the doctor-patient-employee relationships, and how the doctor’s surgery and the workplace might affect the consultation. Such study requires a different epistemological and ontological stance from positivistic frameworks such as naïve rationalism. Parsons, Goffman, Foucault and Bourdieu are not interactionists, but my analysis of their work leads towards using a qualitative interpretivist paradigm to study sickness certification. The next chapter justifies in detail the chosen perspective of symbolic interactionism, in which the social negotiation of meaning is central, and its empirical arm, grounded theory, as the methodological framework chosen for the thesis' original research studies.
Chapter Six: Methodology for Empirical Research and Details of First Empirical Study: Interviews with GPs and Chronic Pain Patients

Introduction

The aims and methodological choices of this study are a response to the nature of the phenomenon under scrutiny, as revealed by the literature and reflections on it, presented in the previous chapters. Regarding the epistemological and ontological aspects of researching sickness certification for chronic pain, the last chapter concluded that whatever approach was chosen, it would have to enable study of the social negotiation of meaning in the doctor-patient-employee set of relationships. This is because sickness certification for chronic pain conditions is not simply an unmediated response to physical pathology, but a social process, to which the generation of shared meanings is central. In the last chapter it was argued that the structure-agency question is vital to consider in relation to sickness certification, as we need to examine how protagonists relate to each other in terms of the power and knowledge each has in the micro-interaction, and also how discourse and structure affect these. The generation of shared meanings can be difficult to access in-depth using quantitative methods, so I chose to work within a qualitative interpretivist paradigm, in order to investigate GPs’ and patients’ views and experiences of sickness certification. Symbolic interactionism was chosen as this approach studies how meaning is negotiated through the micro-interactions that occur in social situations. The empirical arm of symbolic interactionism, grounded theory methods (GTMs) were used to explore the social patterns of sick-listing. I followed the constructivist branch of GTMs (Charmaz, 2006). GTMs informed the study design throughout, including the sampling strategy, how data were collected and analysed. This framework allowed me to study how macro-level forces, such as medicine as a body of practice and knowledge, societal norms about pain and work, and government policy, are in dialectical relationship with the micro-interactional discourse between doctor and patient. My ethnographic approach allowed me to access these micro-interactions.

This chapter describes and provides a rationale for the methodological choices made for both empirical studies reported in the thesis, and goes on to provide a detailed account of how those methods were applied in the first study. The application of methods for the second study is described in chapter eight. The reason for splitting the description of methods in this way is that the design of the second study was influenced by the findings of the first, so it was appropriate to present those findings (in chapter seven) before describing the methods for the second study.

6.1 Rationale for the methodological standpoint adopted in both empirical studies

Both studies adopted the theoretical standpoint of symbolic interactionism and the methodology of Grounded Theory Methods (GTMs). In the following sections I describe the reasons behind these methodological choices and their implications for the sampling strategies, analyses and theory generation that are common to both empirical studies.

6.2 Symbolic Interactionism and Grounded Theory Methods (GTMs)

Quantitative methods, including secondary analysis of routinely collected data and questionnaire surveys, have been successfully employed in many of the studies of sickness certification discussed in previous chapters. Standardised measures are often used in such studies, so that differing experiences and perspectives of stakeholders can be slotted into a certain number of predetermined responses (Patton, 2002). However, such an approach would not have allowed the in-depth exploration of stakeholders’ experiences and the social processes of the sick note consultation required by the research aims. I therefore needed to use qualitative methods to satisfactorily address the research questions. Having decided upon a qualitative approach, there were further ontological and epistemological choices to be made.
Ontology is the philosophical study of the nature of being, and in qualitative research, focuses on considering what is the form and nature of social reality, and what can be known about it (Denzin and Lincoln, 1994). The empirical work of the thesis, (i.e. studies one and two) adopts the ontological assumptions of symbolic interactionism, which posits that meaning is negotiated through social interaction (Mead, 1934; Blumer, 1986; Jeon, 2004; Starks and Brown Trinidad, 2007). Mead (1934) argued that actions can be analysed to consider people’s understanding of each other’s roles and responses in interactions. The purpose of symbolic interactionism is to understand the causes of human action. Symbolic interactionists argue that a central goal of social science should be a meticulous description of human interaction. Elements which might be described include “conflict, role taking, cooperation, negotiation, problem solving, rehearsal of action and situations, definition of the situation, identity, self-direction, symbol [and] social objects” (Charon, 1992, p.206). Symbolic interactionists also emphasise that studying processes is as important as isolating single variables which may lead to certain outcomes. Entitlement to sick leave and notions of acceptable absence and tolerable pain can be seen as socially constructed; decisions about sickness certification as negotiated between GP and patient and dependent on the production of meaning. The social processes taking place between patient and GP are assumed to have structure and both implicit and explicit procedures which shape the production and understanding of meaning. Thus I adopted a symbolic interactionist approach, in order to access how these meanings are negotiated through social interaction.

Charon (1992) stated that the symbolic elements of human behaviour have been neglected as they are not amenable to study using the methods of the natural sciences. Symbolic interactionism posits that we can understand what is going on only if we understand what actors believe about their world. Charon (1992) argued that researchers must reconstruct actors’ realities, via interview (and observation), including asking them for retrospective accounts of their actions. Symbolic interactionists maintain that data must be collected through observing people in real situations through participant observation or interviews, and not in laboratories, so that researchers can “see their [participants’] objects as they see them” (Blumer, 1969, p.50). Whilst many symbolic interactionists use participant observation, the perspective has a range of methods attached to it such as focus groups (which may be part of participant observation, Richardson, 1996). Study one used interviews with doctors and patients. It was originally planned to use participant observation in the next study, to see how protagonists’ experiences of consultations related to what they said in interviews, but many of the doctors interviewed in the first study advised against this on ethical and practical grounds, as they thought it would be too time consuming and difficult to identify suitable chronic pain patients, get their consent and observe consultations. In accordance with the ontological assumptions of symbolic interactionism, both empirical studies used grounded theory methods (GTMs) to inform the sampling, data collection and analysis. Not all symbolic interactionists use GTMs and it can be applied to a range of different data collection methods such as focus groups, observations and interviews, but it grew out of the symbolic interactionist tradition, aiming to formalise what until then had been a rather diverse, eclectic approach to method (Glaser and Strauss, 1967).

Epistemology considers what knowledge is, and how it can become known to us; in qualitative research terms, how we can know about social reality, and what is the relationship between the observer and the observed (Denzin and Lincoln 1994). Symbolic interactionism asserts that social order is maintained at the micro level of social interaction in everyday life, i.e. that we make sense of the world and invest our experiences with meaning by interacting with others. This is not just the imposition of previously existing narratives, but a dynamic process in which meanings are negotiated, shared and revised. This fits well with habitus. In terms of epistemology, symbolic interactionism assumes that there are social realities which can become known to us, through observation. GTMs
epistemology posits that there are categories which help us to understand the assumptions informing individual realities; this makes the shared creation of social reality possible. It is argued that individual realities are expressed through human interaction, which can be observed.

I chose GTMs rather than other interpretative approaches such as phenomenology or discourse analysis as I wanted to construct explanatory theory from the data, rather than simply to describe how phenomena are represented in consciousness, or to understand how people use language to enact identity, which are the central goals of the phenomenological approach and discourse analysis respectively (Starks and Brown Trinidad, 2007). I had considered using narrative analysis, as this considers how people make sense of connected life events and fits well with the illness narratives that the literature on chronic pain patients suggests they experience (Kleinman, 1988). However, I decided to use GTMs in order to go beyond analysis of people’s experiential stories, and rather try to construct theory around the social processes and attendant meanings in the sick-listing consultation.

There are several different schools of grounded theory methodology (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Green and Thorogood, 2004; Charmaz, 2006; Charmaz and Henwood, 2008). Indeed, Charmaz (2006) argues that there are so many schools that GTMs is a useful term for a collection of different methods with some similar principles which can be flexibly applied to research. GTMs have a relatively long history (see, for example, Glaser and Strauss, 1967; Strauss and Corbin, 1998; Charmaz, 2006; Charmaz and Henwood, 2008; Corbin and Strauss, 2008). I will now outline features salient to justifying why I have used constructivist GTMs.

Charmaz (2006) has argued that Glaser and Strauss’ 1967 seminal grounded theory text is based on the assumption that the process of coding and the development of categories and theories reveals a pre-existing social reality. Strauss and Corbin (1998) retained a positivistic leaning, but also acknowledged the role of interpretivism when they discussed how to construct theories from relationships between concepts. Charmaz (2006) takes an even stronger interpretivist line, arguing that our theories merely interpret the world, rather than providing an exact picture of it. She takes the constructivist view that data are generated by research rather than simply being collected. For Charmaz (2006) constructivist GTMs and symbolic interactionism are both interpretivist, sharing assumptions of “emergent, multiple realities, indeterminacy, truth as provisional” (Charmaz, 2006, p.126). Charmaz (2006) suggests that GTMs do not offer verifiable knowledge but “plausible accounts” (ibid, p.132). Bourdieu agrees, arguing that reflexive sociologists should be aware of their research paradigm habitus and must not lose sight of their own subjectivity being produced within the field of academia (Bourdieu, 1977 and 1990). Glaser and Strauss (1967) advocated conducting a literature review after collecting and analysing data in order to minimise the influence of preconceptions derived from earlier research or theory. This implies a degree of objectivity that is arguably unattainable. Even without conducting a literature review the researcher is not a tabula rasa, but rather the product of all their previous experiences and the interpretive constructs that they have given rise to. An alternative strategy, advocated by many researchers (Alvesson and Sköldberg, 2000; Charmaz, 2000, 2006; Henwood and Pidgeon, 2006), is to consciously manage the relationship between self, data collection (including interaction with participants) and analysis, by methodological reflexivity, for example, by attempting to identify pre-conceptions and assumptions that might distort observations and interpretations. Charmaz (2006), noting that academia usually expects a literature review to be conducted prior to data collection, suggests that researchers can use it to sensitive themselves to key concepts, whilst being aware that this might influence their perceptions. The literature review is then acknowledged as part of what one must be reflexive about.
Whether qualitative research simply observes an objective reality or constructs an explanatory narrative, and whether it is possible to reduce bias or merely acknowledge a particular standpoint, are key issues within social research which continue to generate debate and remain unresolved. My standpoint is towards the interpretivist and constructivist end of the continuum. My research provides a partial narrative about sickness certification, mediated by my prior knowledge. However, I have attempted to be reflexive and have utilised methods to minimise bias, e.g. by comparing my initial coding with that of a second reader, while recognising the difficulty of stepping outside my own socio-cultural fields (Bourdieu and Wacquant, 1992). The discussion chapter deals with possible bias in the research and what that might mean for its results and conclusions in more detail.

6.3 Sampling theory

Grounded theory researchers have differing views on the kinds of sampling that GTMs should use. Strauss and Corbin (1990) argue that participants should be selected according to the demographic characteristics of the target population, so that saturation of categories may be achieved (saturation is discussed below). Charmaz (2006) counters that this is too positivistic, as the small sample sizes and lack of random sampling means that GTMs cannot approximate the statistical generalizability of quantitative research. Rather, GTMs aim to fit emerging theories with rich data (Charmaz, 2006, p.101). This can be done using purposive (also called purposeful) sampling (Patton, 2002; Green and Thorogood, 2004). This is when researchers explicitly choose participants who it is anticipated will produce relevant data (Green and Thorogood, 2004) and is consistent with constructivist grounded theory. I used purposive sampling. Patton (2002) discusses how “the logic and power of purposeful sampling lie in selecting information-rich cases for study in-depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry...[this] yields insights and in-depth understanding rather than empirical generalisations” (Patton, 2002, p.230).

Qualitative researchers tend not to use generalizability in the strict sense that quantitative findings from large random-samples can be generalised, but they still want to claim that their findings are transferable to other contexts. Transferability is usually addressed by providing a thick description of the context and participants, so that readers can assess whether the findings might be applicable to the context/population they are interested in (Bowling, 2002; Patton, 2002). I have attempted to do this in the current and results chapter. Also, returning to Patton’s point concerning the power of selecting information-rich cases, I argue my participants constitute such cases, as they were voluntarily providing data based on years of experience of being either a doctor (mean = 21.61; median = 22, see table 6.1, below) or a chronic pain patient (mean = 8.03; median = 7, see table 6.2, below). The practical constraints of conducting doctoral research with limited funding necessitated a pragmatic approach to recruitment which is described in the methods sections relating to each of the empirical studies.

6.4 Saturation

GTMs researchers agree one must collect data until saturation occurs. Glaser and Strauss (1967) defined this as collecting and analysing data until the properties of categories are saturated i.e. when new data fail to generate new theory. Charmaz (2006) emphasises this does not mean simply repetition of patterns in the data, but rather when no new theoretical insights into the main analytical categories emerge. Similarly, Green and Thorogood discuss how saturation is achieving “a conceptually dense, theoretical account of the field of interest in which all categories are fully accounted for” (Green and Thorogood, 2004, p.103). They point out that this is “potentially limitless” (ibid), and Charmaz discusses the difficulty of establishing its legitimacy e.g. it can be seen as teleological and as an artefact of how GTMs researchers collect and organise data.
However, these writers still see it as a useful, indeed a central, part of GTMs, as it forces researchers to reconsider analyses. Charmaz (2006) states researchers should always go back to the data, consider the coding and re-code them if necessary. I used questions set down by Charmaz (2006, p.113) to try to determine the point of saturation. These included asking what sense I had made of comparisons between data and data, and code and code, how such comparisons had illuminated theoretical categories, and whether I saw any new conceptual relationships. This is known as the constant comparison method and is the backbone of GTMs, as it makes researchers refine their analysis whilst remaining grounded in the empirical data collected (Green and Thorogood, 2004; Charmaz, 2006). As an example of how I considered saturation, it became apparent that “living with stigma” was a category pertinent to the analysis of every patient’s interview data. The data were not saturated in this category until I had considered what stigma meant to different patients, how they enacted it (did they minimise their pain condition, cover it, politically join with other sufferers to fortify themselves against “normals” etc.) and how it affected sickness certification consultations. Table 6.3 below gives further details and examples of all parts of the data analysis process.

There is some evidence that saturation often occurs at around 12 interviews (Guest et al., 2006), but it partly depends on the breadth of the research questions and the homogeneity or heterogeneity of the sample. The number of GPs (13) was as expected. However, patients’ data were more diverse and I judged that thematic saturation was not reached until 26 had been interviewed. Four more patients had already given informed consent, and it was unethical not to interview them once they had invested in the study materials, so 30 patients were interviewed in total. The data of the last four were useful in confirming that saturation had been achieved. Whilst there were of course similarities between chronic pain patients’ narratives, there were also many particulars in different cases and indeed one of the main tensions patients felt was that they are lumped together as a homogenous group whereas there is considerable variation in how individuals interacted with different doctors, employers, family members, benefit agencies etc.

6.5 Methods adopted in study one and research questions

Having established the broad methodological standpoint that informed both empirical studies, I now turn to a detailed description of the methods deployed in study one. The study focused on the doctor-patient dyad in relation to sickness certification and sought to answer the following research questions, which chapter three showed were important to consider:

- How do GPs describe their experiences of sickness certification for chronic pain?
- What are the difficulties they face and what strategies do they employ to address them?
- What are the attitudes and beliefs of GPs, regarding the introduction of the fit note, and education programme on work and health, for sickness certification for chronic pain patients?
- How do patients with chronic pain describe their experiences of sickness certification?
- What are the difficulties they face and what strategies do they employ to address them?
- What are the attitudes and beliefs of patients with chronic pain, regarding the introduction of the fit note, and education programme on work and health?
An additional research objective was added which was to ask doctors and patients what they thought of the ethics and pragmatics of a possible second study, observing general practice consultations.

6.6 Recruitment of GP participants

I originally obtained ethical and research and design (R and D) approvals to mail-drop up to 120 GP surgeries regarding the study. This number was recommended by a Primary Care Research Network (PCRN) advisor as necessary in order to allow for response and attrition rates in order to secure 12 GP participants (the PCRN is an organisation funded by the Department of Health to support primary care research). In fact, the GPs who participated were recruited by two other approved methods before this large mail-drop took place, so I did not need to do it and doctors were recruited in two ways as follows:

Firstly, I had already made contact with a number of research active GPs in the South-West at various networking activities. As a result of this, I was invited to attend three different practice meetings to make a five minute presentation about the study, which yielded three interested doctors, one from each meeting. These doctors were given a study information pack (composed of poster, information sheet, and two informed consent sheets, one to keep for their records and one to return to me) and all participated.

Secondly, I publicised the study at three separate GP training events, using the same 5 minute presentation; this was allowed in return for my assisting with event management. The training was on psychological flexibility around opioid prescribing for pain, which may have introduced selection bias; this is returned to in the discussion chapter. Eighty-one GPs attended in total and forty-three interested GPs were given the study information pack to return to me. Thirteen provided their written informed consent. Three subsequently withdrew, citing lack of time, so ten were interviewed from this method of recruitment. Data were collected on all GPs concerning length of service, type of practice, training in pain and OH to try to ascertain their typical characteristics (see table 6.1 below).

Eligible GPs were straightforward to identify as there were no exclusion criteria, as long as they were willing and able to give written informed consent, could adequately understand verbal explanations or written information in English and did not have unmet special communication needs (as there was no budget for translators, or special needs provision). Therefore, GPs were not screened but all interested ones given a study information pack with informed consent paperwork and those who returned the latter were interviewed. Out of the thirteen GPs, eleven were from different practices and two from the same practice. Table 6.1 below provides more information on salient characteristics of the GP participants.
6.7 Recruitment of chronic pain patients

Ethical and R and D approvals were initially granted to publicise the study using the first two of the following three methods, targeting the South-West, but these were slow to recruit. Therefore, an ethical amendment was applied for and granted, allowing me to advertise for participants on pain charities’ websites. This recruitment method yielded participants from all over the UK.

Firstly, I contacted all 24 surgeries listed on the local PCT website and asked them to display posters in their waiting rooms. All agreed. The poster gave brief details of the study, and provided removable strips bearing my email and telephone number. The posters were not a comprehensive screening tool but did ask patients if they lived with a chronic pain condition which kept them off work, or might do, and asked anyone interested to contact me to find out more. People who emailed me were asked to set up a short telephone screening appointment. People who called were screened over the phone to see if they were suitable for recruitment. The screening tool is in appendix five, the poster in appendix twelve.

Secondly, I approached potential participants by going to outpatient and inpatient settings in secondary and tertiary care in the South-West. I attended events put on by two different pain services to gain the trust of the staff, so that staff would feel happy allowing me to promote the study to patients, and then establishing rapport with the patients to see
if anyone was interested in participating. The first pain service comprised a therapy group in a secondary level hospital setting; I attended this group three times. The second pain service involved my observing one-to-one sessions with occupational therapists and pain patients in a tertiary level setting. Once accepted by clinicians and patients, I explained the proposed research to patients and showed them the study poster. Patients who were happy to be given an information pack took one away with them.

Thirdly, patients were targeted via an ethically approved advertisement placed on pain charities’ websites from May till August 2010:
- Pain support: [http://www.painsupport.co.uk](http://www.painsupport.co.uk)
- Pelvic Pain: [http://www.pelvicpain.org.uk](http://www.pelvicpain.org.uk)
- FMA UK: [http://www.fmauk.org](http://www.fmauk.org)
- Backcare: [http://backcare.org.uk](http://backcare.org.uk)

Patients who responded to the advert were sent an information pack, and if still interested, screened as described above. Eligible patients then returned their informed consent paperwork, prior to being interviewed.

*Figure 6.2: Flowchart of patient recruitment*
Table 6.2 below provides more information on salient characteristics of the chronic pain patient participants. Due to confidentiality, it is not known whether some of patients came from the same surgeries as the doctors; it is possible that some did. Participants received information packs at least one week before their interviews occurred, to allow sufficient time for patients to reflect on their decision to participate. Any participant queries were discussed, then written informed consent was provided by participants prior to interviews taking place.

6.8 Inclusion and exclusion criteria

Inclusion criteria for participants who were doctors:
- All GPs who gave informed consent to participate were included (providing they did not need to be excluded as per the criteria below)

Exclusion criteria for participants who were doctors:
- Participants had to be able to understand verbal explanations or written information in English. Participants were judged unlikely to respond to the letters and posters if they had insufficient English to understand them. Also, the recruitment screening was delivered in English, so a judgement was made about participants’ English at this point. There were some participants for whom English was not their first language, but all were able to understand and communicate in English more than adequately for the purposes of the study
- Participants who had special communication needs which were not already met by the surgery or their own personal resources were to be excluded (there was an insufficient budget attached to this study to enable special communication needs to be met). No such participants came forward

Inclusion criteria for participants who were chronic pain patients:
- Be 18 years old or over
- Be able to give informed consent
- Be in full or part-time paid employment and have needed a sick note in the last year (including those currently on sick leave) OR get sick notes for incapacity benefit
- Have experienced pain in any part of their body that lasted for over three months, at any time within the last year. This time frame was taken from definitions of chronic pain discussed in chapter two i.e. it is often defined as pain that lasts over three months, and due to acute episodes and recurrence, is seen as intractable, greatly impacting on the individual (Waddell, 1998, after Von Korff et al. 1992)
- Have consulted their GP in the last year or planned to consult in the next month

Exclusion criteria for participants who were chronic pain patients:
- People who had consulted their GP in the last year, but the consultation excluded reference to chronic pain, or who planned to consult in the next month, but did not intend to discuss chronic pain
- People who had consulted, or planned to consult, their GP about chronic pain, but had other symptoms which they felt were more important in terms of how their lives were affected (at work if they worked or generally if they did not)
- People who could not adequately understand verbal explanations or written information in English, or who had special communication needs (there was an insufficient budget attached to this study to enable special communication needs to be met). No such participants came forward
6.9 Characteristics of GP participants

I recorded characteristics of GPs, which the literature review had suggested might influence the course of sickness certification consultations, by asking brief questions at the beginning of each interview (see appendix six for the questions and interview schedule). These characteristics were:

- gender
- years practising
- whether they worked full or part-time
- whether they characterised their practice as rural, urban or mixed
- whether they had any specialist training in occupational health
- whether they had any specialist training in chronic pain management
- the country in which they trained as doctors

I have not recorded whether GPs were recruited at the training events or in practice meetings, since I gave the same presentation at both recruitment venues. Summary data of the GPs’ recorded characteristics can be seen in table 6.1 below (they are aggregated to avoid compromising individuals’ anonymity).

Table 6.1 – Summary data of recruited GPs’ characteristics (n = 13)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>F = 3, M = 10</td>
</tr>
<tr>
<td>Years practising*</td>
<td>Mean 21.61, Median 22, Range 12-26</td>
</tr>
<tr>
<td>Works full-time or part-time</td>
<td>FT = 9, PT = 4</td>
</tr>
<tr>
<td>Practice is rural (R), urban (U) or mixed (M)</td>
<td>R = 7, U = 6, M = 0</td>
</tr>
<tr>
<td>Pain management training</td>
<td>No training = 12, Diploma in Palliative Care and Diploma in Acupuncture = 1</td>
</tr>
<tr>
<td>OH training</td>
<td>No training = 9, Training = 4 (Diploma in OH)</td>
</tr>
<tr>
<td>Country of primary medical education</td>
<td>UK = 12, Australia = 1</td>
</tr>
</tbody>
</table>

*The data were normally distributed (i.e. the mean and median were not significantly different), as the Shapiro-Wilk gave p = 0.323, see tests of normality in appendix seven.

6.10 Characteristics of chronic pain patient participants

As with the doctors, I recorded characteristics of patients which the literature review had suggested might influence the course of sickness certification consultations, by asking brief questions at the beginning of each interview (see appendix eight for the questions and interview schedule). These characteristics were:

- gender
- whether they worked full or part-time, or did not work and if so why (on sick leave, being retired on medical grounds, personal choice)
- diagnosis or pain condition as described by participant and length of time suffering

I also recorded:
• how they were recruited (as there were different methods which may have affected data collection)
• how they were interviewed (telephone or face-to-face, as this affected data collection)

Again, summary data of the patients’ recorded characteristics can be seen in table 6.2 below (aggregated to protect anonymity). The patients’ pain conditions were more difficult to tabulate e.g. one patient had been originally diagnosed with MS, then fibromyalgia, but preferred to be classified in the category of ‘undiagnosed general chronic pain’ for the purposes of the study.

Table 6.2 – Summary data of recruited patients’ characteristics (n = 30)

<table>
<thead>
<tr>
<th>Gender</th>
<th>F = 24</th>
<th>M = 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Works full-time, part-time, or does not work (no W)</td>
<td>W FT = 15</td>
<td>W PT = 5</td>
</tr>
<tr>
<td></td>
<td>No W = 10</td>
<td></td>
</tr>
<tr>
<td>Recruited how?</td>
<td>GP surgery posters = 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2˚ care = 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3˚ care = 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internet = 21</td>
<td></td>
</tr>
<tr>
<td>Interviews conducted by telephone (T) or face-to-face (F)</td>
<td>T = 27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F = 3</td>
<td></td>
</tr>
<tr>
<td>Years suffering from pain*</td>
<td>Mean = 8.03</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Median = 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Range = 1-20</td>
<td></td>
</tr>
<tr>
<td>Conditions participants described suffering from (some had multiple morbidities)</td>
<td>Undiagnosed = 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fibromyalgia = 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General back pain = 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lower back pain = 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abdominal pain = 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pelvic pain = 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arthritis = 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rheumatoid arthritis, osteo-arthritis, inflammatory arthritis, upper limb pain, CRPS, tennis elbow, DISH, Ehlers-Danos type 3, knee pain, RSI = 1 each</td>
<td></td>
</tr>
</tbody>
</table>

*The data were normally distributed (i.e. the mean and median were not significantly different), as the Shapiro-Wilk gave p = 0.092, see tests of normality in appendix nine)

6.11 Data collection

Semi-structured interviews were chosen to collect the data as they are flexible in responding to participants’ talk. They allow an encouraging forum for exploring norms and values and are likely to provide rich data (Denzin and Lincoln, 1994), which Patton (2002) noted was important when using purposive sampling.

Interview questions were developed to explore the issues raised in the research questions. For doctors these were:
1. Awareness of and views on the Government education programme that work is good for us, and also on the new fit note
2. How a doctor decides if a chronic pain patient needs signing off
3. Views on the next proposed PhD study (observation of GP-patient consultations)
4. Summary questions designed to ensure participants had been able to raise all the key points they wished

For patients these were:
1. Awareness of and views on the Government education programme that work is good for us, and also on the new fit note
2. What they considered when deciding if they needed signing off, regarding their chronic pain condition and external factors such as the doctor-patient relationship
3. Views on the next proposed PhD study (observation of GP-patient consultations)
4. Summary questions designed to ensure participants had been able to raise all the key points they wished

The questions were designed to reflect a symbolic interactionist approach i.e. to elicit information about respondents’ experiences of the meaning of events. For example, one of the doctors’ questions under theme 2 was “How do you make sense of whether or not patient x should be signed off?”

To facilitate the collection of rich data, writing contemporaneous field notes is recommended (Charmaz, 2006). I wrote notes on every interview immediately after it finished e.g. recording if I felt a particular view had been strongly expressed, or if I wanted to remember some nuance for when I analysed that particular participant’s data. I also wrote notes on anything particular about the setting, e.g. how face-to-face settings may have affected the talk.

I carried copies of the old sick note, new fit note and related guidance and educational materials, in case people wanted to see them, and also to use them as prompts if necessary, in face-to-face interviews. This could not be done for telephone interviews. Where necessary, I used elaborative, retrospective and comparative probes (after Kreuger, 1998), in order to ask for: examples of something, more detail on a previous utterance, and to explore related elements. Participants were keen to talk, so these probes were not necessary to add to data but they were useful to refine them.

The interview schedule was informed by an initial literature review and preliminary discussions with stakeholders. A small pilot study with two GPs and two patients allowed me to test the schedule, and to practise my interview style and using the digital recorders. I used two handheld recorders simultaneously, in case one failed (this did not happen at the pilot stage, but did later on, so I was grateful I had been advised to dual record). I interviewed the two GPs over the phone and the two patients face-to-face, so I had practised both modes of delivery. Nothing substantive was changed as a result of the pilot, but it was very useful to practise using careful wording, emphasis, tone of voice and body language, so as not to lead participants in any particular direction. I also refined the schedule marginally, as I slightly reduced the number of questions after the pilot.

The successful pilot gave me a vantage point from which to begin data collection and analysis, but it was important to remain open to changing questions if necessary as interviews took place. As the schedule was semi-structured, I was able to change the wording and emphasis of some questions without changing the overall theme. I slightly reduced the number of questions I was asking; as interviews progressed, I realised the open questions were very complex, and participants were responding at length, raising other issues in their answers. It is appropriate in grounded theory principled interviews to narrow the topic range to gather specific data to develop theoretical frameworks (Charmaz, 2006). Some grounded theorists such as Glaser (1998) might see my use of probes and my slight modification of questions as forcing the data into some of my preconceptions (derived from the literature review, and early interviews). However, Charmaz suggests that “an open ended interview guide is hardly of the same order as
imposing received codes on collected data...thinking through how to word open-ended questions helps novices to avoid blurtling out loaded questions and to avert forcing responses into narrow categories” (Charmaz, 2006, p.18: see also Pidgeon, 1996). I found that slightly reducing the number of questions, and probing lengthy answers, was a more effective way to elicit rich data than rigidly adhering to the initial interview guide.

Interviews lasted approximately 60 minutes. All interviews were one-to-one, except in the case of one patient, whose partner also contributed at the patient’s request. All participants were given the option of being interviewed face-to-face or over the phone. All GPs were interviewed face-to-face in their surgeries: GPs are busy, and I could not pay them for their time, so it became apparent I would need to be as accommodating as possible in order to collect their data. Most GPs saw me straight after their surgeries ended, or in their lunch hours. As they were all within a 50 mile radius of Bath, so I was able to travel to their surgeries.

Twenty-seven out of thirty patients were interviewed over the phone, mostly as they lived all over the UK so it was not practical to travel to interview them and in some cases they stated that they simply preferred the convenience of being telephoned. Also, some patients preferred phone interviews as they liked the relative anonymity; others wanted to be interviewed face-to-face as they felt this engendered more trust. This dual method has implications for what is said in interview, so I recorded which medium, phone or face-to-face, was used. Rubin and Rubin (1995) raised concerns that telephone interviews are inferior to face-to-face for fostering rapport and recognising subtle nuances of communication but Welsh et al. (2012) argued that they can assist interviewees’ comfort with discussing potentially sensitive topics. The discussion chapter returns to this point. The three patients who were interviewed face-to-face all came to a research space at the University. Initially, it had been planned to collect data from focus groups, but experience showed that GPs wanted to be interviewed in their places of work, as they are so busy, and patients often wanted to be interviewed individually due to the sensitive nature of their experiences of living with chronic pain.

Interviews took place from April to October 2010, after the fit note came into use on 6th April 2010. Participants discussed both sick and fit notes, as they were encouraged to discuss experiences within the past year. Interview technique to build rapport with informants included reminding them at the start that everything would be kept confidential and they did not have to answer any questions they did not want to. I started with simple demographics questions as an ice-breaker, and shaped the interview so that harder questions about potentially emotional issues were towards the middle, with easier questions about the proposed next PhD study at the end. Prompts were used when necessary.

6.12 Data analysis

All interview data were transcribed. I transcribed half myself and used a professional transcriber for the remainder, both using verbatim transcription. I read the third party transcriptions while listening to the recordings to check for transcribing errors and achieve greater immersion in the data. I knew the data well without transcribing it all myself, as I had interviewed all participants, and could recall many details of the experience, including particular phrases and tones of voice etc. I read through all the transcripts before coding, to further the immersion process, using my field notes to check my recall of nuances.

I used constructivist methods of grounded theory data analysis, following the detailed guidance given by Charmaz (2006) and also taking account of the advice of other researchers open to a constructivist paradigm (Green and Thorogood, 2004). GTMs require data to be coded. A code is simply a conceptual label to identify the phenomena indicated by the data under analysis (Glaser and Strauss, 1967). This involves two types
of coding: initial (also called “open” in much GTMs literature e.g. see Green and Thorogood, 2004) and focused. The researcher should also take field notes and make memos to inform their coding. As explained above, I wrote field notes immediately after each interview, in order to record anything I thought might be pertinent to the subsequent data analysis. Field notes concerned particularly strong emphases I felt the participant had made, any information they had divulged in the process of setting up the interviews, and anything important about the setting e.g. whether or not it was on the phone or face-to-face, and in a couple of cases, why the participant seemed distracted and how this affected the data. For example, one doctor was almost monosyllabic to start with, making their data difficult to code, and making me question why they had agreed to take part. When I modified my interview questions and asked why they were participating, they became animated about the problems of not being an occupational health specialist and the interview progressed much more effectively. My field notes recorded that they felt ambivalent about participating, as they stated that they considered the study topic worthwhile but also felt under time pressure and were very tired. The field notes were useful when I came to analyse the interview, as they helped to make sense of quite difficult data. GTMs suggest it is also useful to write memos, but this usually occurs further along in the process, after some initial coding has been done, and during focused coding. The two types of coding are now explained.

Initial coding entailed studying fragments of data, usually word-by-word or line-by-line, in order to apply preliminary codes to the data. Such careful study makes the researcher pay very close attention to the data and consider nuances within them (Green and Thorogood, 2004). The coding is called “open” as it is meant to “open up” or “fracture” data, i.e. generate many potential codes at this stage. Codes are initially meant to be gerunds as this gives a stronger sense of participants’ actions, helping researchers to consider matters from interviewees’ perspectives (Charmaz, 2006). Gerunds can later be formulated as topic nouns, but using them did help me to try to gain an insider’s viewpoint. For example, I initially used “grieving” not “grief” which did strengthen my feeling for participants’ status, before “grief” became part of the focused code “stigma” later on. I also used some “in vivo” codes (participants’ own words which seem especially telling; Glaser and Strauss, 1967) as part of initial coding. For example, one participant said “there is no box for chronic pain patients like me” which encapsulated many other patients’ views. Not all in vivo codes are analytically useful but this one was retained in later focused coding as it was part of the analysis of the contested category of being a chronic pain patient.

Charmaz (2006) suggests the research team code data separately at this initial point then meet to compare their work. It was not practical for my supervisory team to code all or even most of the data as there were so many generated from approximately 43 hours of interviews. Therefore, I carried out initial coding for half the transcripts, then one research team-member took uncoded copies of four of the transcripts I had done (and relevant field notes) to do initial coding himself. We then met to discuss our coding, finding broad consensus was quite quickly reached. Once we had reached consensus, I coded the remaining transcripts alone, doing the rest of the initial coding and all of the focused coding. We found in practice that I had a privileged position as the interviewer, as I could remember the tones of voice and context of most of the data, and had access to the recordings as well as the transcripts.

After initial coding, I carried out focused coding. This is when the most useful initial codes (those which seem most significant and frequent) are tested extensively against the data to decide which make the most analytical sense. Testing took the form of using Green and Thorogood’s coding paradigm, asking a set of questions about each code, viz. “what gives rise to the category? What is its context? What are the interactional strategies by which it is handled and what are the consequences of those strategies?” (Green and Thorogood, 2004, p.182). Green and Thorogood (2004) use these questions as part of
formal axial coding (Strauss and Corbin, 1990) which seeks to examine subcategories by building a “dense texture of relationships around the ‘axis’ of a category” (Strauss, 1987. p.64, cited by Charmaz, 2006, p.60). Charmaz argues that the precise methods of doing axial coding, set out by Strauss and Corbin (1990), need not be used, as they are only one way of making links, and can be too prescriptive as they are formulated on positivistic grounds. Charmaz (2006) uses a more flexible approach of re-examining data linearly, and diagrammatically, in order to create her subcategories. I followed her approach, and also borrowed Green and Thorogood’s questions, as above, to give me a framework in which to interrogate my initial codes in order to find which ones were the most useful analytically. Glaser and Strauss (1967) highlight that focused codes should not simply be descriptive but become categories for analysis. Charmaz (2006) emphasises that these categories should encompass almost all the data incisively. This does not mean that all data will be coded, as some will be irrelevant, but all the experiences described by participants should be consistent with the theoretical framework that emerges from the data.

Green and Thorogood (2004) argue that researchers must pay special attention to deviant or negative cases (exceptions within the dataset which test emerging theory) to ensure that a thorough and credible account of the data is achieved. Charmaz (2006) discusses how we must be careful not to import these negative cases but agrees that if they are in the data, they suggest our theories need refinement. I found that virtually every chronic pain patient used the word “stigma” and discussed what that meant to them, but two patients said they had never experienced any stigmatisation. These would appear to be deviant cases. However, under further analysis, I argued that in fact these two patients covered their chronic pain conditions successfully, but at great expense to many areas of their lives in an effort to attain acceptance that turned out to be only partial or ‘phantom’ (Goffman, 1968). Hence these two patients’ data pertaining to stigma were not deviant cases when more fully analysed.

Throughout the process of focused coding, and at pertinent points of initial coding, I wrote memos to assist with my analysis. Early memos recorded what I saw happening and what meanings I thought research participants attributed to actions, in order to provide codes. My field notes were useful in developing these memos. Later memos helped to make comparisons between codes, developing analytical claims and supporting these with empirical evidence (Charmaz, 2006).

Table 6.3 below shows each main part of the data analysis process, with examples. NVivo 8 was used to manage the data analysis. I was aware NVivo does not do the thinking or analysis for the researcher (Weitzman, 2000) but its functionality was very useful. For example, its different search commands facilitated my performance of constant comparison.
### Table 6.3: Summary of data analysis methods with examples (study one)

<table>
<thead>
<tr>
<th>Data analysis methods</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial coding:</strong> word-by-word or line-by-line study to generate preliminary codes</td>
<td>“I’m 41 years old and I can’t even make my own bed” [patient 2] I coded this as “grieving”, informed by the tone of voice on the recording as well as the transcript.</td>
</tr>
<tr>
<td><strong>Field notes,</strong> contemporaneously written by the interviewer, used to check for nuance.</td>
<td>This participant had previously revealed in the interview that she was a new mother. She found this status rewarding but it also exacerbated her sadness at being unable to manage physical tasks. She emphasised this several times and I noted how strong her feelings of loss appeared.</td>
</tr>
<tr>
<td><strong>Inter-coder agreement:</strong> a different researcher coded a section of data using transcripts and field notes. We discussed interpretations until we reached consensus</td>
<td>“I’m 41 years old and I can’t even make my own bed” [patient 2] The re-coder coded this as “despair/frustration”, from the transcript only; the re-coder did not listen to the recording but did have access to the field notes. When we discussed this code, we considered field notes as well as my interpretation of the participant’s tone of voice and agreed that “grieving” fit the data the closest out of three codes.</td>
</tr>
<tr>
<td><strong>Memo writing:</strong> to compare codes and develop analysis. Inductive building of theory.</td>
<td>Memo: “Grief&quot; as a subcategory of the focused code “Stigma&quot;. These codes could be retained as distinct but in so many cases, patients’ sense of loss, caused by their chronic pain condition, appeared to feed in to their sense of stigmatisation and vice versa. They felt that they were “without…” so many things (including basic physical competency, the respect accorded in our society to the able bodied, and to workers), and were angry (a feeling also associated with stigma) but were also extremely sad...these chronic pain patients felt as they were “stuck in loss&quot; and saw that others can see this loss too. Many patients expended so much effort in “trying to pass themselves off as normal&quot; (Goffman, 1968) that they were exhausted and even if they managed to “pass&quot; in one area of life (e.g. retaining some work, sometimes refusing a sick note against advice) they suffered in other areas (e.g. being unable to complete any housework, then feeling ashamed and reinforcing grief that they were not “normal”). Four doctors referred to a sense of “victimhood&quot; that they said “understandably” pain patients feel. More than one doctor suggested that they knew they could be seen to be stigmatising patients by the use of the term ‘victim” which has almost come to be pejorative (McLaughlin, 2012). These doctors were extremely aware that their patients were grieving for the stigma accorded to their conditions and varied in the degrees to which they thought they could help. Doctors were, to differing degrees, empathetic with this “grief” but had to maintain professional distance and worked to ameliorate the “grief” that came as part of the stigma in practical ways. E.g. doctors gave progressively shorter sick notes to try to get non-working patients to re-engage with appropriate (physically safe, reasonably satisfying) work, if possible. Doctors negotiated quite gently, as by far the majority said they would not see it as part of their role to directly refuse a sick note if one was asked for, but they would try to reduce their lengths. But the doctors all saw appropriate work as a means of reducing stigma, hence grief.</td>
</tr>
<tr>
<td><strong>Focused coding:</strong> the most useful initial codes were tested against the data to see which made the most analytic sense. Deductive; theory of stigma being a useful analytical category, with grief as a subcategory, tested against the data.</td>
<td>“grieving” was tested against many other data and found to fit most, although not all, segments. For example, patient 5 stated “I’ve lost the person I used to be&quot;. The context of data segments, and interactional strategies by which they were handled, were crucial. In this instance, the male participant had been told by both his doctor and wife that his condition had lessened his capacity to work, but he was struggling to accept this. As recommended by Charmaz (2006) “grieving&quot; was converted to the topic noun “grief&quot; as a focused code. This code eventually became a subcategory of the focused code “stigma&quot; (see memo above) as “stigma&quot; was conceptually able to account for so many of the data and their context.</td>
</tr>
</tbody>
</table>
In summary, consistent with constructivist grounded theory’s ontology, the analysis was sequential and iterative and also inductive (theory was built up from empirical data, by exploring relationships between codes and themes) and deductive (theories were tested against the data e.g. by considering deviant cases). This process gave a rich theoretical account, grounded in empirical data. Findings have been contextualised and related to the literature review. The contextualisation is discussed in the results chapter (chapter seven) and the relationship to the bodies of literature discussed previously is highlighted more fully in the discussion chapter (ten).

6.13 Ethics and Research and Design (R and D) approvals

NHS ethical approval was given by Bath Local Research Ethics Committee (or LREC; reference 09/H0101/72). The modest research costs were funded by my studentship, an unrestricted grant from the University of Bath (reference EA-FH1005), so there is no conflict of interests to declare. These costs comprised postage for study information packs, petrol for travelling to interviews and transcribing fees. Full R and D approvals were gained from ten different R and D bodies (NHS and Primary Care Trusts). Originally, these were Bath and North East Somerset (BANES); the Royal United Hospital, Bath (RUH); the Royal National Hospital for Rheumatic Diseases, Bath (RNHRD); Bristol, North Somerset and South Gloucestershire; Gloucestershire; Taunton and Somerset; Swindon; Wiltshire (North, West and South). Later, Newcastle and Scotland were added to this list, in response to patients living in these areas who wanted to participate. Ethical approval was also awarded from the Department for Health and the Department of Psychology at the University of Bath, in line with internal procedures. Ethics approval was granted to video as well as audio-record interviews, but this was deemed unnecessary eventually, for the kind of GTMs data collection and analysis decided upon. Similarly, approval was granted to interview GP surgery staff and GPs, in case there was a need to access nurse practitioners’ or others’ views, but this was not necessary as so much rich data was collected from doctors.

NHS ethics required approval being gained for the following documents (asterisked ones are in appendices as are those pertinent to study replication):

- Protocol
- IRAS (Integrated Research Application System) main form
- SSI (Site Specific Information) forms
- Peer review
- Funding letter
- Sponsor letter
- Insurance indemnity proof
- Participant info sheet including consent forms – GPs (appendix ten)*
- Participant info sheet including consent forms – patients (appendix eleven)*
- Interview schedule (original) – GPs (appendix six)*
- Interview schedule (original) – patients (appendix eight)*
- Recruitment poster for patients (appendix twelve)*
- Recruitment poster for GPs (appendix thirteen)*
- Recruitment charity advert (appendix fourteen)*
- Recruitment screening too (appendix five)*
- CVs of all research team members (three supervisors and I)
- Research passport for me
- All amended documents

Reports on the research findings also had to be submitted to participants and all ethical and R and D bodies at the end of the study. I attended the Ethics Committee meeting with one supervisor: I was not called to answer any questions as the Committee were satisfied with the documentation and gave their approval for the study. I have not
reproduced some documents, such as the protocol, and reports on research findings, as
the methodology and results chapters are an expansion of these. Similarly, I have not
reproduced documents pertaining to the technical acceptance of the study by the ethics
committee, such as the funding, sponsor and insurance indemnity letters.

Ethical considerations raised by the project and how they were dealt with:

Consent and participant information arrangements about debriefing.
Participants were given written information about what the study entailed, their right to
withdraw themselves and their data from the study at any time, and arrangements for
keeping their data confidential. They were asked to read this information before giving
their written consent. A debrief in the form of a written report was given to the participants
on completion of the data analysis.

Confidentiality, data protection and storage.
Names and signatures were needed for the consent forms, so anonymity was not
possible. However, names were not required other than this, so once participants had
signed the consent form, they were given a numerical code and identified this way for the
rest of the study. As data were audio recorded, it was impossible to pseudonymise them
before analysis. However, only the supervisory team and the ethically-bound professional
transcriber were able to listen to the data and everything which has been written up has
been pseudonymised so it cannot reasonably be used to identify any individual.

The LREC co-ordinator recommended that data should be securely stored for five
years, in line with current research governance guidelines. While the data were being
transcribed and analysed, they were stored on a University computer saved in password
protected folders, and only my supervisors and I could access the relevant folder. The
personal data on the informed consent sheets are being kept in a locked cabinet in a
lockable room at the University of Bath. All data are being protected in accordance with
the Data Protection Act (1998) and the Department of Health’s NHS Code of
Confidentiality (2003). In the information sheet, participants were informed of the data
protection and storage arrangements.

The scope of disclosure was limited to ensure that any data which are published will
not be identifiable as belonging to any one participant. In accordance with BPS ethical
guidelines, breaches of confidentiality had to be restricted to those exceptional
circumstances under which there appears to be sufficient evidence to raise serious
concern about: (a) the safety of participants; (b) the safety of other persons who may be
endangered by the client’s behaviour; or (c) the health, welfare or safety of vulnerable
adults. No breaches were necessary in this study.

Time allowed to decide whether to take part.
Potential study participants always need time to consider fully the implications of
taking part in research - they should be able to ask questions and reflect and not be
rushed into decisions. All participants had at least a week to decide whether or not to take
part.

Risk to participants.
It is impossible to claim that participating in any research carries no risk e.g. in this
study, a participant may have been daunted by considering a return to work issue.
However, the study adhered to the BPS principle that when participants enter a study they
should not, in so doing, increase the likelihood of coming to harm, and individuals should
not be induced to take risks that are greater than those that they would normally
encounter in their life outside research (BPS, 2006). There was information in the study
information leaflet concerning sources of support, should any participant have felt that
taking part caused harm (e.g. they discussed a delicate issue surrounding return to work and felt distressed by this). Participants were informed of procedures for contacting the researcher, within a reasonable time period following participation, should stress, potential harm, or related questions or concern have arisen despite the ethical precautions taken. I have not been made aware of any such problems occurring. As this study involved discussing experiences that participants may have regarded as personal, participants were also protected from stress by the assurance that answers to personal questions need not be given. As a qualified teacher with many years’ pastoral experience, and who has also been trained in qualitative methods of data collection, I feel that I was sensitive to participants’ worries. Participants were given details of support organisations such as NHS Direct, in the participant information pack, in case they needed further support.

**Participant and researcher safety when interviewing individual participants.**

I had an enhanced CRB check, which the Ethics Committee required, and which some R and D bodies wanted to see, although some did not. This was designed to provide some protection for participants from the approval bodies’ perspective, although the information sheet did not discuss the CRB system. In terms of my own safety, I followed standard procedure i.e. a log of face-to-face interviews was given to a supervisor and I contacted him at the beginning and end of these. I carried a mobile telephone at all times during fieldwork.

In summary, I have presented the rationale for the methodological standpoint adopted in both empirical studies and provided a detailed description of how they were applied in the first study. Chapter seven provides a detailed description of how the methods were applied in the second study, but before that the results of study one are presented in the following chapter.
Chapter Seven: The Doctor/Patient Dimension

Introduction

The issuing of a sick note is done by one person, who is nearly always a GP. Yet this solitary, specific act is just one moment in a process that extends backwards and forwards across time, and entails interaction with others, including: patients, family and friends who may encourage health problems to be defined as worthy of both medical attention and work absence; colleagues who may contribute to normative expectations regarding attendance of absence when ill; and employers who receive the sick note and play a role in shaping patients’ return to work. Evidence relating to this complex web of micro-interactions and structural factors was reviewed in chapter three and is discussed in the concluding chapter in the light of findings from both the empirical studies in the thesis. This study focuses on the doctor-patient axis, not because it represents the entire process of sick-listing but because it provides the prism through which a much broader process and range of factors are refracted. Throughout both results chapters, levels of consensus are indicated when themes showed some agreement from GPs, patients or both groups. I rarely show the numbers of people who contributed to each theme, as this suggests a representativeness which ignores how themes’ strengths were also expressed by degrees of assertion and fervour (Wenger, 1988: Gabe et al., 2002).

Interviews with 13 GPs and 30 patients who had experienced managing or being on sick leave for chronic pain were conducted, in order to address the following research questions:

- How do GPs describe their experiences of sickness certification for chronic pain?
- What are the difficulties they face and what strategies do they employ to address them?
- What are the attitudes and beliefs of GPs, regarding the introduction of the fit note, and education programme on work and health, for sickness certification for chronic pain patients?
- How do patients with chronic pain describe their experiences of sickness certification?
- What are the difficulties they face and what strategies do they employ to address them?
- What are the attitudes and beliefs of patients with chronic pain, regarding the introduction of the fit note, and education programme on work and health?

I begin by reporting doctors’ perspectives, then discuss patients’ views. Woven throughout are considerations of the challenges posed by sick-listing for chronic pain, and how sick notes, and the new fit note, may partially restore disrupted roles.

7.1. The doctor’s dilemma: sick-listing under uncertainty

This section relates to research question one, as it explores the dilemmas faced by GPs when negotiating sick-listing, how they describe these and how they attempt to overcome them.

7.1a Difficulties assessing chronic pain conditions

In many chronic pain cases, there is either no observable pathology or pathology that does not fit neatly with patients’ accounts of suffering. This is true for other conditions often seen in general practice, such as depression, chronic fatigue syndrome, and even many viruses. Doctors in this study did not claim that chronic pain sick-listing was harder than other areas in which signs and diagnoses may be uncertain. However, in accordance with the literature review presented in chapter three, findings from the interviews with doctors suggest that chronic pain is a good exemplar of the kind of these subjective or
medically unexplained conditions which make sick-listing especially challenging for stakeholders.

The non-specific nature of chronic pain exemplifies the tension in general practice discourse between the hypothetico-deductive strand and biopsychosocial model. Doctors explained that they often asked patients how they felt and discussed their functioning, used simple 1-10 pain scales, assessed guarding, examined bodies, and tried to bring all these things to a point of coherence. There were often tensions between what GPs thought these different methods were suggesting; additionally, using any one of these methods could bring difficulties with interpretation:

“Building up experience of patients’ enactment, is how we benchmark the particular patient’s pain in front of us…some patients hunch and guard and some have learned to accept [their pain] so it’s harder to gauge their level of pain” [GP11]

Doctors recognised guarding as behaviour that prevents or alleviates pain such as bracing or limping (Prkachin et al., 2007). It was a way for patients to enact pain and a way for GPs to interpret their enactment to assess the pain level. As the quotation above demonstrates, it can be a difficult process, as the patient may guard reactively to protect themselves or may do it more consciously both to protect and to communicate their problem. Then the GP must interpret this enactment: the quotation above suggests this skill comes with cumulative clinical experience, which can be brought to bear in individual cases, but interpretation can still be hard. On this uncertain terrain, some doctors felt de-skilled, as if occupying a role for which they are still not sufficiently well trained, and which they often did not value as highly as the traditional clinical method. One doctor said that he found it hard that some elements of the communication of pain were effectively out of his hands:

“in the end, it comes down to the patient, and some are not as eloquent as others” [GP8].

These doctors felt what one neatly termed “intellectual discomfort” [GP6] regarding the contestable aspects of assessing chronic pain. This could be initially challenging to the ideal roles of the doctor and patient as it involved making judgements based on subjectivity:

“I certainly don’t think it’s right for GPs to put themselves in the position of judgement and it’s amazing…the percentage of patients who feel threatened by that” [GP5]

“You know, back pain is a huge grey area and there is such a subjective element to it and who am I to say, “You haven’t got back pain” and who am I to say that you can’t do your job and that you’re not distressed by it and that you can’t sleep with it. It’s not for me to judge really” [GP8]

However, doctors had strategies to cope with this “judgement”, such as trusting their patients’ accounts. Some did this unreservedly as the way to manage subjectivity:

“Well, you just have to take what they say on trust, and that’s fine, I can’t behave in another way and do this job properly” [GP5]

Most doctors essentially trusted patients but used phrases such as “to some extent” implying how it may be difficult to rely solely on patient accounts. The next quotation shows a doctor’s view that one must trust patients but also be aware the situation is complex and there could be “underlying” issues which the doctor must then unpack:
“to some extent you have to take people at face value but then, I think, you also have to say, “Well, there’s no disc damage, I think it’s mainly muscular, I think it’s mechanical, I think you need to mobilise and I’ll give you this much time by which time I would expect you to …” and most people are okay with that and if they’re not then you worry that there’s something else underlying.” [GP8]

And several doctors found different methods of assessing chronic pain hard to reconcile, hence challenging:

“I don’t take on trust what they say, I listen to them, to their accounts, and I look at them, and examine them, and I try to match up the two. And that’s hard, especially if they don’t always match” [GP4]

Some doctors found it hard being unable to construct plausible diagnostic hypotheses:

“I think the majority of them end up with the slightly unsatisfactory fibromyalgia diagnosis and I’m not entirely happy about that, though I think we’re learning more about it as time goes on” [GP5].

A minority of doctors found the subjective elements of assessing chronic pain positively satisfying as the attendant negotiations became very interesting to them:

“all these chronic pain and all these people, I think that in many ways it’s the most interesting part of the job, because you have these negotiations, you know, and you can make predictions based on knowing them, about what, how they’ll react and you know, I find that fascinating. More interesting than, it’s that rash, have that pill.” [GP6]

“And then when they come in I would be looking for congruence between verbal and non-verbal behaviour…and if their verbal and non-verbal behaviour, the way they sit, the way they move, is incongruent, then I think it’s important not to take their complaints of pain at face value, that’s what it amounts to…I try to talk to them about an area that hasn’t endlessly been explored already, then you can get underneath their shell and try to get a feel for what’s actually going on.” [GP11]

All GPs felt that their role was to support the patient, whether or not a diagnosis had been given, and whether or not they felt the pain was due to pathology:

“It’s not whether they’ve got pain or not, or whether they’re genuine or not, none of that matters. It’s how they’re going to get better. That’s all that matters.” [GP11].

This doctor was explicit that he did not mind if he felt a patient conceptualised psychosocial suffering as physical pain – he simply saw that as a sign that they needed help.

The clinical gaze used to be about looking inside the body to find evidence of physical pathology (Foucault, 1973), whereas now the rise of the biopsychosocial model has led to the emergence of a new expertise, organised around knowledge of psychosocial causes, and emphasising the skills of exploring these issues with patients. Kleinman (1988) and Bury (1982) have written about using ethnographic methods in medical practice, to situate the patient’s symptoms within a broader narrative about their life experiences and social situation. Some of the doctors seemed comfortable with this, such as GP 11 above, who alluded to the process of getting beneath the appearance of the patient’s presentation and tapping into the essence of their problems. However, GP 4’s quotation above showed the incongruence between listening to patients and looking at them was hard, as the uncertainty is outside the traditional biomedical model.
7.1b Difficulties assessing workability

Unsurprisingly, given the difficulties with assessing chronic pain conditions, doctors reported that trying to decide whether pain warranted a sick note was also problematic. Doctors frequently discussed the challenges presented by the sick-listing consultation for chronic pain patients in terms of being unable to see physical pathology:

“It’s extremely difficult [to make the capability decision] because you can’t see somebody’s pain. Quite often though the patients just bounce into the surgery and don’t look like they’ve got pain at all. And that’s – they’re the problem ones. They say they’ve got agonising back pain and they can’t possibly work, but there is no objective evidence for it.” [GP2].

This doctor discussed his discomfort at making judgments without “objective evidence”; his role became distasteful to him and he partly coped by positing patients as “the problem ones” with whom one expects to have conflict. This can be seen as the doctor struggling to work outside the clinical gaze. The doctor may have been socialised in Foucauldian terms into working within the discursive formation of biomedicine whereas now something outside that is being expected of him. Similarly, doctors discussed frustration that they are not OH specialists and do not know much about many types of workplace, yet are being made to assess workability:

“The trouble is, of course, as a GP, I don’t necessarily know much about their work” [GP6]

Additionally, doctors discussed how wider structural factors impacted on workability decisions, usually making them more likely to sick-list. These factors included: psychosocial issues in patients’ lives; poor working conditions; difficult relationships with management, and lack of specialist pain management resources. It is not just the organisation of healthcare which is constraining how doctors act but the organisation of very broad domains, such as the nature of work. Doctors were frustrated that they perceive they cannot do much to change such external factors:

“The difficulty is you often can’t do anything about them” [GP2]

“There’s just nothing that we can really offer people other than the MIN [a tertiary level pain hospital in Bath] and let’s face it the MIN is very oversubscribed. The trouble is also once they’ve been through that system then they come out the other side and maybe they are better for a bit but inevitably they come back here again and then what do we do? You know, there’s no on-going input.” [GP8]

This disrupts the ideal doctor role through revolving door syndrome. It is not seen as the patient’s or doctor’s fault, as it is down to external circumstances, but doctors feel deskilled in response “and then what do we do?”. Often, a sick note was given in lieu of doctors feeling they could offer anything else helpful. Social structures hence constrained the micro-interaction.

7.1c Challenges for the GP role: ‘I’m not a health policeman’

This in vivo code encapsulated doctors’ views. All stated that they were “the patient’s advocate” [GP8, 13], using either this exact term, or similar phrases such as “I’m on the patient’s side” [GP3]. Both phrases suggest there are forces out there to be fought against, normally conceptualised as a harsh state wanting to send ill people back to work prematurely. That all doctors discussed advocacy freely, without the interview schedule prompting it, suggests the habitus of general practice may include it. All GPs thought that appropriate work is good for most people but that:
“for some people, work is the issue, so then I write them a sick note” [GP12]

and

“I’m not going to send them back if I think that will make them worse, whatever the DWP or anyone else says”[GP4].

Even if doctors felt patients were “swinging the lead” [GP8] they did not see it as their role to police this:

“the problem we’ve got with chronic pain patients... there is a real sense of, “What on earth do we do with these people?” …For example, this chap I was telling you about who has been off work for 10 years with fibromyalgia and who I’m quite certain is fabricating his illness because I’ve seen him around the town and he seems to be absolutely fine whenever I’ve seen him. So, I think he is just basically ‘swinging the lead’ but I don’t think that it’s my job to come down on him … I suppose I feel a bit under-supported by the state, by the social work system and I think that they do need to be coming down a bit harder on these people and if there are genuine pathologies, giving us some sort of outlet.”[GP8]

This relates to the contradiction outlined above i.e. the tension between biological reductionism and the psychosocial model. Biological reductionism does not usually entail value judgements or issues of morality, at least not directly. But this approach has limitations when it comes to managing illnesses that have a psychosocial component. However, addressing psychosocial issues tends to draw doctors into making value judgements with which they feel extremely uncomfortable. On one hand, GP 8 judged that his patient was “swinging the lead” but on the other, wanted to support the patient by “not coming down on him” as this is not the doctor’s job. This leaves doctors in a difficult position; a partial solution is to refer the patient on to others. Many doctors discussed non-medical factors contributing to patients’ unwillingness or inability to engage with work and how they need “help” [GP5] with patients from other professionals who can deal with particularly the social element of the biopsychosocial model.

Many GPs also felt that they are in an invidious position as they are being placed in conflict with employers as well as the Government, and that this is in neither doctors’ nor patients’ best interests:

“I think a lot of employers, I have to say, kind of get occupational health opinions ‘on the cheap’ by sending patients to their GP and actually, as I say, we’re not really qualified and we don’t know enough about the job and we’ve got 10-minute appointments. Occupational health really needs longer than that and, you know, you’re dealing with important issues here; you’re dealing with people’s livelihoods, sick pay and all the rest of it. So, although I can see the rationale behind it … we’ve been put in a slightly difficult position here and we haven’t got a choice” [GP8]

GPs often conceptualised their role as fighting against the state on behalf of the patient, and also that it is “not my job” to conduct the kind of social control they suggested sick-listing reduction is being cast as. GPs stated that they can advise patients, but do not want (or indeed think they can) force them into anything:

“I think we are in a unique position and we can certainly guide people…Well, I’m not a health policeman and that’s the thing I always try to point out to them and at the end of the day I can only advise them.” [GP8]
“The patient’s agenda is key, you know, I don’t think we, as medical people, have as much influence on where the agenda goes as the Government may think” [GP7]

Many doctors felt strongly that the Government assumes they will police the back-to-work agenda, whereas this is not what doctors are there to do.

7.1d GP-patient conflict

GPs frequently discussed conflict with patients over how to negotiate and explain the workability decision. GPs reported patients wanted a sick note when the doctor did not think it warranted, or vice versa: GPs wanted to sign patients off but they wanted to work. Although the interviews were focused on chronic pain conditions, GPs did refer to other conditions for which sick-listing was problematic (e.g. depression, a common co-morbidity) and it appeared that it was the uncertain nature of conditions which made the capability decision difficult rather than pain per se. Rarely, the unexplained nature of some chronic pain conditions made the capability decision easier, as GPs felt they simply had to err on the side of caution and sign someone off. Yet in most cases, there were extra challenges to both GP and patient roles inherent in the uncertainty. Chronic pain may defy neat diagnosis and management, hence the doctor may remain in uncertainty:

“It’s [pain] a bit more complicated. It’s not like you’re absolutely sure they couldn’t work. It’s just that they are so certain they can’t work” [GP1]

Who made the capability decision was also challenging as patients felt they knew their jobs and their pain best, discussed further when reporting patients’ perspectives in section 2 below.

Most conflict occurred when GPs did not want to sick-list but the patient wanted to be signed off. All GPs said most patients were open to negotiation, and simply wanted the best for themselves, whether that meant return to work or not. Yet all GPs commented that they had experienced some patients who were “intransigent” [GP6] in their determination to be sick-listed, against doctors’ advice. GPs experienced role conflict as they wanted to apply their expertise to do what was best for the patient and also wanted to be patient-led, seeing themselves as a partner in treatment choices.

In terms of how they managed sick note negotiations, the GPs were ranged along a continuum from a minority who expressed views such as:

“I’m really quite mean and niggardly with the way that I prescribe and the way that I give sick notes. I’m really conservative about that, a conservative prescriber and conservative issuer of sick notes” [GP3]

to the other end of the scale, where the majority of GPs agreed:

“the chap who asks for a sick note, gets one” [GP4].

Even those GPs who saw themselves as “conservative” agreed that:

“I think I just see myself as the patient’s advocate ultimately so if that’s what they want then that’s what they’ll get. I’ll try and persuade them perhaps if there is another way but ultimately if I fail in that then so be it because I’ll have to be there looking after them afterwards anyway.” [GP13]

GPs reported feeling uncomfortable writing a sick note when they were unsure of its appropriateness, as this jarred with their clinical objectivity:
“If I as a GP can find a clear diagnosis, then it’s all much easier, because you can say to
the patient ‘look, this is the estimated recovery time’ etc. etc. and whereas when you can’t,
it’s all much harder to negotiate and the patient’s likely to want a sick note more” [GP4]

Lack of diagnosis muddies the waters of the classical Parsonian sick role, as it becomes
less clear for how long the appropriate and temporary recovery time period is. GPs also
reported feeling uncomfortable at writing sick notes when they were sure that this was not
in the patient’s best interest, as it erodes their authority

“it’s very hard to, really hard to, refuse a sick note. I can’t think of any instance when I
have because I tend to think that the conflict it would involve is not worth the hassle really”
[GP8]

“All doctors stated that in some cases they are happy that a sick note is the proper
response. All were keen to emphasise that they thought it was a minority of patients who
they judged were straightforwardly “swinging the lead” [GP8]. They felt that current
societal rhetoric assumes many more people are malingering than is the case, and that in
fact people are often dealing with very difficult circumstances:

“I don’t think people are malingerers – I think that some of my patients, they have so much
going on for them, that it’s not that I think they are malingerers, it’s rather that I wonder
how they function at all!” [GP10]

Only four doctors said they had ever refused a sick note. Two said they had done so only
once, some time ago, and would never do so again as it had ruined their relationship with
that patient. Two GPs discussed how they would occasionally refuse a sick note, but both
went on to show that this would be carefully managed over time, and also that they would
usually involve other healthcare professionals in this decision.

Most doctors recognised that they do give sick notes when they do not think they are
clinically indicated, but felt that they do not issue them as freely as they perceived the
Government and press suggests. Doctors explained that they would rarely if ever refuse a
sick note but would try to negotiate strategies to manage the situation. Doctors varied in
the degree to which they would actively negotiate. Some would only do so in a relatively
cursory way:

“I mean you know, someone’s asked for something and I don’t think it’s appropriate I
usually say yes but I think that could be for a shorter period or something like that so I
suppose there’s a brief negotiation there but I don’t, I don’t get myself into conflict
situations over a sick note. I sort of feel life’s a bit too short for that really.” [GP12]
Other doctors related their unwillingness to refuse a note to their conviction that it is not their job to do so, as they needed to think about their on-going relationship with the patient:

“I think ultimately if they want a sick note, they’ll get it. I might try and persuade them back to work and advise them that it perhaps is in their interest but there are some people who are determined to have it and then I don’t see it as my job to stop that. I know that they will be assessed by a benefits doctor and they're not looking for a long-term relationship with the patient or the rest of their family. I suppose I would begrudgingly give the note in the knowledge that there’s another doctor who’s independent and doesn’t have that long-term relationship who will actually make a judgement as to whether they’re fit or not”. [GP13]

Other doctors were more assertive, managing to set targets whilst still maintaining that they would not refuse to sick-list:

“I would never refuse a sick note as then we get into a situation of conflict and that’s no good for anyone as someone has to back down and lose face. It’s about managing expectations. I would give shorter and shorter sick notes and I’d say in one consultation that the next sick note would be shorter so I am setting up that situation.” [GP10]

Other strategies discussed by doctors included writing to employers to try to get targeted support for patients (which tended to get very little response), and emphasising the health benefits of work.

Sometimes, conflict occurred because doctors wanted to sick-list but patients preferred to work. Doctors appeared to mind this less than feeling pressurised into sick-listing, partly as it was rare. Their reduction in discomfort is more consistent with allowing them to conform to Parsons’ ideal types; the sympathetic doctor and stoical patient. It also seemed to be because of the symbolic nature of the sick note, as offering to write one and having this refused was not as distressing to GPs, appearing to erode their authority less. Indeed, they did not even conceptualise it as “conflict”, more as offering advice which the patient is at liberty not to follow:

“I’m not giving doctor’s orders, I’m authenticating or validating what they’ve already decided at some level, but they didn’t want to say it to themselves, or they couldn’t, because of the, you know, protestant work ethic stuff “ [GP11]

Doctors discussed how medics tend to be socialised into a strong work ethic and several mentioned their own illness behaviour (or lack of it; how they carry on regardless). There was a sense they admired patients who had the “protestant work ethic” as it was close to their own. Doctors also understood powerful financial and psychological reasons for wanting to stay at work, especially in an economic downturn.

7.1e Summary: sick-listing for chronic pain is problematic for the doctor

Although instances of overt conflict with the patient are rare, sickness certification for chronic pain can generate tension in the doctor-patient relationship. Doctors are uncomfortable in the role of ‘health policeman’: even if they have moral concerns about the issuing of a sick note that they feel is not justified, they remain reluctant to be seen as coercing the patient back to work. Issuing a sick note can ease tension but many doctors are left with residual dissatisfaction, feeling that that its issue may not have been in the patient's best interests and that there is little external support.
7.2 Patients’ experiences of sick-listing

This section relates to research question two, as it explores the dilemmas faced by patients when negotiating the provision of sick notes, how they describe these and how they attempt to overcome them. In common with findings from interviews with doctors, the uncertain nature of chronic pain rendered the capability decision challenging for many patients. Patients generally felt confident they could get a sick note if they wanted one but were sometimes distressed by having to step outside the role of ideal patient to get one. Patients also perceived that GPs departed from the ideal doctor role during sick-listing consultations.

7.2a The patient’s search for validation through diagnosis

A major point of conflict was whether or not a diagnosis had been reached. A very small minority of patients did not mind a lack of diagnosis but by far the majority wanted one to explain and validate their suffering to themselves and others:

“I know, and my GP knows, that the man in the street’s back might look like mine and doesn’t cause him any pain…my GP is really good most of the time, but I still feel judged, as I’ve got just this one tiny spot [a test result] and everything else is clear but it causes me such pain” [patient 1]

Patients felt a diagnosis, or at least clear pathology, lessened their fears that others did not believe their pain was as bad as they described. Mostly, patients referred to the wider community, as well as or instead of their GP, when discussing being disbelieved. They were sensitive to press reports of benefit cheating, and worried about neighbours and colleagues seeing them apparently well if they were able to put out the rubbish or walk easily, on a day when their pain was not so bad. Patients pushed GPs for diagnoses or evidence of pathology so that they could feel legitimised:

“It’s easier to explain things to others if I can say it’s this disc or that disc and not just back ache. Then they take me more seriously” [patient 13]

Most patients did not consciously link whether or not a diagnosis had been reached to whether or not they easily gained a sick note. However, a striking in vivo code which encapsulated many patients’ views was:

“Trouble is, they don’t have a box for me” [patient 27].

This patient was reflecting on how she and her doctor decided which box to tick on the sick-listing forms, and how this was harder without a clear diagnosis.

Section 7.1a above reported that GPs believed their role was to support the patient, whether or not a diagnosis was offered, and whether or they felt the pain was due to pathology, as their view was that someone who presented saying they were in pain was suffering and needed help. Yet patients found this view challenging, as it opened them up to feeling they were not believed. Patients did themselves discuss how not all pain patients might be “real” [patient 1] which made individuals anxious to be categorised as “genuine” [patient 15]:

“I turned up in the waiting room [of IB assessors], and sort of sat there, I looked around and every other person in there, and some 17 year old lad, who looked perfectly fit, and I just thought, this is a messed up system. Because you can see why they are trying to put all of these measures and changes in to stop it being abused, because it is relatively easy to turn up and say, I’ve got a bad back” [patient 1]
This patient had been both believed and disbelieved in her interactions with healthcare professionals and in common with many patients, feared being tainted by the perception that there were a few patients who were in some way “cheating” [patient 26]:

“my greatest wish is that there was some way of identifying the genuine people at the start and then never using those devices [Work Capability Assessments] against them” [patient 23]

As with doctors, these issues around whether or not there is observable evidence of physical pathology, and if such evidence is consistent with patients’ reports of symptoms, appear to cause tension for the patient: issues of trust and what it is to be an ideal patient are brought to the fore.

7.2b Enacting pain and “playing the game”: performing the role of the ideal patient

Absence of observable pathology, or pathology that did not match patients’ accounts of suffering, was problematic. It meant that the emphasis was on patients’ ability to enact pain through body language, self-reports of symptoms and their effect on everyday life. This is a departure from expectations, because ‘normally’ pathology speaks for itself, and absence of pathology indicates health. Several patients referred to the “game” they have to play to show they can enact and articulate what is going for them:

“I sort of have to manage my back condition with doctors and it’s like playing a game of chess almost” [patient 14]

and

“At the start I didn’t know how to play the game” [patient 25].

Patients recognised it is hard to enact and describe pain: they did not blame doctors for not understanding but felt that they had failed at being patients:

“Well, I couldn't describe it properly, in terms of how the GP understood” [patient 10].

Having to persuade the doctor that absence of pathology does not mean health (and more specifically fitness for work) posits the patient as a supplicant, and more importantly as one who is talking up their symptoms rather than stoically making light of them, as one who is seeking to prolong the sick role rather than exit it. Patient 1 showed this when she said:

“Unfortunately the system makes people do that, you’ve got to demonstrate your worst days”.

“Unfortunately” suggested she did not like being thus positioned and felt her choices were constrained.

7.2c Conflict with the doctor over sick-listing

Generally, patients did not overtly problematize sickness certification as they felt that if they wanted a sick note, they would get one. Also, many patients actively wanted to stay in work and felt genuine agreement with their GP that they needed a sick note as an appropriate, temporary repair measure. In such instances, the sick note functioned as an objective measure of legitimate entry to the sick role. However, many patients still felt stigmatised by the sickness certification consultation as they had to behave in ways that were uncomfortable for them, to get sick-listed. Just as with enacting and describing their chronic pain condition, several patients discussed having to “play the system” [patient 7]
to get a sick note. They did not like this behaviour as it led to their feeling tainted, but they saw themselves as having little option:

“\textit{I must admit I have routinely, over the last six years, made damn sure somebody does see me when my back is bad, because I think it’s just too easy to say, you know, to wait till you’re better and then go down the doctors. I talk to fight, if you know what I mean. But then you realise underneath, actually I wish I wasn’t fighting}” [patient 1]

Patients’ accounts also highlighted the difficulty of enacting what is often a fluctuating chronic pain condition:

“\textit{I didn’t like my GPs before – I just didn’t like the face that they pulled, like, “Oh, again”. They would do the sick note but I would leave their practice with a very guilty feeling and I was feeling like a criminal sometimes. You know, it [the pain] was real… I looked healthy, but it was true}” [patient 6].

Chronic pain’s “\textit{shocking unpredictability}” [patient 17] made it very difficult to assess workability as it waxed and waned, and again, contributed to patients’ feeling they needed to present at their worst moments.

Even once patients had got their sick note, they still felt devalued by what they had to do and say to get it:

“\textit{I’ve said that on scale of 1 to 10, this is a 10 and they did not take that seriously, I think they just thought I was exaggerating. So then I said “imagine you put a hot iron across your stomach, and iron yourself – that’s how it feels. And that worked – he [GP] got it. And I…I got my note}” [patient 3].

This patient explained that she did not initially want to be sick-listed and felt that her earlier resilience had worked against her once her pain became unbearable.

Patient 9 illustrated a point made by several others; the patients’ need to “\textit{win}” in the sick-listing interaction, because one feels one is losing in other elements of life:

“\textit{That element of, I’m still in control, because control is a big issue when you chronically suffer you feel like you’ve got no control, because you have no control over yourself}.”

Another patient’s account showed poor communication between her and her doctor in terms of how her pain affected her:

“\textit{then he’s written fibromyalgia down as well on it [the note], ticked you may be fit for work taking account of the following advice, then he’s ticked the amended duties. Now that was because when I went, he said, “Is it any better?” I said, “From how it was, yes, but it isn’t right. It still keeps swelling up and everything else”. As you’re talking to him, it’s almost as if he just doesn’t want to know and doesn’t want to listen…it’s almost as if… If you’re not committing suicide, he doesn’t want to know. If I sat there in floods of tears and was screaming and shouting and everything else, perhaps he’d take more notice of me}” [patient 20]

This quotation refers to the need to enact pain in order to persuade the GP that the condition is serious. This is likely to make the patient feel like a fraud, even if they are only enacting pain that really is present on other occasions. This account also exemplifies how being refused the “not fit for work” box (i.e. not being sick-listed) led to patients feeling stigmatised as they perceived their accounts were trivialised. Whether or not patients wanted a sick note, there was tension around the subjectivity of some chronic pain, as
patients thought that their own accounts should be an important part of the sick-listing process, but they did not see these accounts being fully recognised as central. When patients discussed their subjectivity it tended to be in the context of on-going conflict between the patient and doctor, rather than seen as a helpful part of the consultation:

“only I know how I feel and whether I can work”[ patient 19]

and

“I know myself better than they do”[patient 17]

Here the patients posited themselves outside the traditional patient role.

A minority of patients reported no conflict whatsoever between their doctors and themselves:

“one of the things I love about my GP is, I give her a form, she looks at it, hands it back to me, says write what you want and I’ll sign it”. [patient 21].

Although this patient said she “loved” her doctor’s behaviour, her data suggested that she was ambivalent about it as she also showed her GP’s compliance disrupted how she thought a doctor should act:

“She isn’t the best doctor, but she’s certainly the most pliable doctor. So if it comes to things like that, sometimes when I go to the GP I don’t get the best GP care. Because I’ve had to sacrifice that in order to get somebody who will just write the reports”. [patient 21]

Both the Parsonian sick role and social order of the clinic are now inverted: instead of the patient being obliged to comply with the doctor, the GP behaves as the patient wishes. Additionally, this patient felt tense as she recognised that another doctor might invest her chronic pain with a different set of meanings:

“It is good [having this particular GP], but because it’s not consistent, or it’s not an objective thing, it’s a subjective thing, it leaves you really on a knife edge the whole time. What if that doctor leaves the practice?”[patient 21]

This patient is exercising choice to see which GP she wants, but the choice is constrained as she perceives that she has sacrificed high quality medical care in order to get sick-listed.

Patients also experienced conflict with the doctor when they wanted to work but the doctor wanted to sick-list them. As for doctors, patients expressed less distress in this situation than when wanting a sick note from a doctor disinclined to provide one. Again, this seemed to be because patients felt that society (including doctors) values the protestant work ethic. Therefore, remaining at work when perhaps one would be better off recovering elsewhere can be seen as heroic:

“I was at work when I shouldn’t have been. I know that. I’m the first to hold my hand up but when you’ve got other members of staff off and you don’t want to let people down and everything, you push yourself”[patient 30]

Other patients felt pressure to stay at work, due to money, the recession or other worries such as how a new workplace would view sick leave:
“But then I changed jobs and my GP had actually given me a sick note when I was just starting the job but I ... because I’d just changed jobs .... I didn’t take that. I took the sick notes but I went into work. He felt that I needed the rest and the time out and he recommended it but obviously it was my choice and he respected my choice.”[patient 10]

These findings, and those from the interviews with doctors, reported above, suggest that patients often have the final say in sick-listing. This is less problematic if that decision involves something society sanctions (work is good). Presenteeism was constructed as positive or simply pragmatic to avoid censure, as it allowed the patient to cover up their spoiled identity. Patients perceived that doctors were usually happy to “go along with” presenteeism:

“I should have stopped before I did, because in hindsight I just got worse ... but I was scared of what they’d think, and my doctor just went along with me”[patient 24].

This also allows the ideal (resilient) patient and ideal (sympathetic) doctor to be enacted.

7.2d Summary: Sickness certification for chronic pain is problematic for the patient. Patients often feel that they understand their illness better than the doctor and are better able to assess their fitness for work. This sets up tension, as on the one hand patients are asking for a sick note, and requiring the doctor, who still has a lot of power to negotiate, to make a judgment, but on the other hand desire their own accounts of suffering to be recognised. Patients want to be believed above all else, which firstly means being given a diagnosis, or at least some evidence of clear pathology, and secondly a sick note. If the doctor suggests that patients might be better returning to work rather than receiving a sick note, this can be read as a negative moral judgement, leaving the patient feeling undermined or delegitimised. On the other hand, conflict over being offered a sick note when one does not initially want one is less stigmatising as the patient can construct themselves as a strong and determined worker in the face of adversity and the doctor as sympathetic, in line with Parsons’ ideal types. There is an undercurrent of strategizing, and whilst patients were conscious of game-playing, using such language, they felt very constrained by the healthcare and benefit systems, as well as by societal views on who deserves to be unwell.

7.3 The symbolic meaning of the sick note: negotiating the social order of the clinic

This section relates to research questions one and two, as I argue that issuing a sick note does not overturn the tensions and problems identified above, and may add to some of them, but is a strategy employed by doctors to resolve some of the dilemmas experienced as it goes some way to restoring the social order of the clinic. This concept suggests that social order in complex organisations such as healthcare is something that is worked at continually, through negotiation and bargaining rather than simply being prescribed by formal structures (Strauss et al., 1963). Doctors and patients know explicit and implicit rules concerning doctors’ authority to advise and patients’ obligation to comply but modern notions of patient participation are weakening this. Protagonists must find other ways of reaching consensus such as including patients’ accounts of their lived experience (Armstrong, 1989).

Sick-listing challenges doctor-patient consensus but the sick note can be a partial means of solving some of the problems identified earlier. For the patient, the sick note is not just a desired means of exiting work, but also a symbolic legitimation of the reality of their illness, an official sanction for the sick role. It is an affirmation that their efforts to enact chronic pain and fulfil the role of ideal patient have been recognised and partly validated. For the doctor it is at least an exit route from a possibly difficult consultation and a way to satisfy the patient’s demands, partially re-establishing medical authority. The doctor can give a sick note to recognise that external circumstances, as well as pain, can
be difficult for their patient, showing sympathy whilst simultaneously enacting some elements of the gatekeeper role. At the same time, they are aware that this may lead to problems later:

“But also bound up in that is there aren’t any, you know, there aren’t really any nice jobs for them. But we do have problems with stopping the sick notes in those certain circumstances.” [GP1]

Doctors were often sympathetic to the poorly paid, badly structured jobs that they believed many of their patients did, but also thought most people needed to be in work for psychological as well as practical reasons. One doctor used sick notes very dramatically, simultaneously upholding his gatekeeper role whilst trying to draw out the patient:

“They’re [sick notes] usually in the drawer. We could sort of play games about touching the drawer and then closing it again, and doing this. In other words, you’ve [the patient] got to work a bit harder than that. Yeah, or you could put it on tantalisingly, put it on the table like that, not filled in. It’s theatre isn’t it, to some extent.” [GP11]

He overtly used sick notes to gradually coax people back to work:

“And it is a sort of negotiation, isn’t it, you need a lever, and then what you can offer to somebody is a sick note… the sick note becomes a lever. But you’ve got to understand what you’re levering towards…. I wouldn’t want, I would try not to get into a situation where there was no shift on their part. Because people sometimes have a long journey to make and they can only, and it’s a scary journey, so they can, you know, you have to find a step that they can make. And there are very few people that can’t make a small step. a sick note might just be too big a step at that time not to be given –I’ve done this so many times, write a note like I have dozens of times before for the same person. And then say, return to work. You know, it’s like- You get your certificate. There’s your certificate, your achievement, so it comes at the end really.” [GP11]

This GP said he never refused to give a sick note, but gave them out at the end of a consultation, once patients had engaged with him in discussing the nature of their problems. Thus he actively used sick notes not in lieu of a cure, but to effect movement towards healthy working patterns, as well as to retain authority.

Sickness certification was also experienced as difficult by doctors and patients as both parties recognised that doctors didn’t know very much about many different types of jobs. It was a way that doctors’ role was diminished as it made it harder to decide if a certain level and type of pain warranted a sick note. Of course, doctors made intelligent inferences about many jobs, questioning patients about what exactly their job entailed and how they felt their pain condition made work hard or impossible. Doctors also recognised the subtleties of different workplaces:

“There’s factories and there’s factories or there’s shops and shops, aren’t there, and some of the shops are nice, wide, light, airy aisles and every manual handling device you can imagine whereas the charity shop you go up and down three flights of twisting stairs, carrying boxes as you go” [GP13]

Doctors with OH training suggested that an extremely helpful element was visiting a variety of workplaces, but this is impossible to do for each individual patient. Doctors largely got around these issues by “listening to the patient” [GPs 1, 11 and 13] and trusting what they say about their job. Most doctors trusted most patients’ accounts:

“I don’t think people set out to mislead us actually, it’s not in their interest” [GP13]
but also said a minority of patients’ descriptions of their jobs could be skewed:

“there are some patients who basically have jobs that they didn't like at the best of times. And that's where the problem lies really, the motivation to return is poor.” [GP9].

In these cases, the sick note can be used to allow both parties to feel (at least superficially) that the consultation has been successful. The doctor gives the note, usually with provisos such as making it as short as possible, to help get over the problem of not knowing much about the workplace, as the note then functions as an objective device showing the doctor has listened to the patient. The patient gets the “achievement” [GP11] of the note, so is legitimated. However, the doctors expressed frustration that they are obliged to decide in situations where they cannot know all pertinent facts clearly. For some doctors, this frustration was minor when set against their belief that helping patients stay in work can be a crucial part of general practice. Yet for other doctors, they wanted “help” [GP5] as they felt their generalism was being asked to extend too far:

“Well, I've got a bit of occupational health training you see and I think that in some respects they're asking GPs, who have no occupational health training and who have no knowledge of the person's workplace, to make judgements about occupational fitness and I'm not sure that we're necessarily the best people for that” [GP8]

For their part, patients felt initially that they had enacted their pain sufficiently to get the sick note but still felt residual unease about having to do so again when the sick note ended – feeling on a “knife edge” was discussed in this context by three patients [1, 17 and 18].

Patient 9 exemplified how many patients adopt a mechanistic approach to the consultation, going through the motions to get a sick note, but feeling distressed and stigmatised by the process:

“I've got one because I've persisted, but I've had reluctance, I've had it given to me with great reluctance. They've got to the point where they've got fed up with me. And they've done it just to get rid of me.” [patient 9]

Thus “winning” comes at a cost – one is no longer cast as the ideal patient but instead as the difficult patient who is prepared to “persist”, perhaps a pyrrhic victory.

In summary, sick-listing is a symbolic act that partly re-establishes the social order of the clinic. Doctors can simultaneously enact sympathy whilst making patients engage with the medical gatekeeping role; patients receive a state-sanctioned sick role status. However, the note can leave both parties dissatisfied. Patients feel concerned about going through a difficult enactment again if they want to extend their sick leave; doctors can be wary that gaps in their knowledge base are being exposed, and biomedical authority remains challenged by occupational and psychological elements of sick-listing.

The final section looks at participants’ views and experience of the policy response to sickness certification, (i.e. fit notes and the national training programme that work is good for us) in order to consider their effect on sick-listing for chronic pain.

7.4 The policy response to rising sickness certification rates
This section relates to research questions three and four, as it considers the attitudes and beliefs of doctors and chronic pain patients, regarding the national education programme that work is good for our health and well-being and the introduction of the fit note.
7.4a ‘Work is good for our health’: Supported in general but not always in particular

Every GP and every patient interviewed agreed that in principle, appropriate work (e.g. work in which physical risk factors are controlled) is beneficial to our health and well-being. Every GP was aware that the Government was publicising this agenda but only two had come across any of its training materials. Most patients had heard that the Government was trying to reduce the number of benefit recipients but only some that the health benefits of work were being emphasised. The drive to reduce benefits was often conceptualised as a ruthless state seeking to reduce financial outlay:

“If I wasn’t claiming any money from anybody, nobody would care. They wouldn’t talk about the benefits of working and benefits to society they wouldn’t give a stuff about these things. What it boils down to is money. The rest of it is just kind of fancy rhetoric.” [patient 1]

This patient was unable to stay in the sick role without stigma, as the rules of the sick role were being violated by a chronic condition which was not allowing her to get better. However, all patients, whether or not they were not currently working, commented on the psychological and financial benefits of work, e.g. patient 27 stated that:

“people feel absolutely worthless, without work”.

All the patients with jobs were making great efforts to overcome challenging barriers (such as the fluctuating and often unpredictable nature of chronic pain, dealt with by flexi-time where possible) because they valued their work financially and socially. Nonetheless, patients also talked of personal experiences which made work extremely difficult, if not impossible, to engage in. Several of those who were working emphasised that they do so at the expense of many aspects of their life, summed up by patient 19:

“I’m currently managing to work full-time but at the complete expense of my social life. I’m always resting to recover from work and to ensure that I can work again the next day or the following week. My mum thinks having another half [a partner] would help me as there’d be someone around to look out for me etc. but constantly complains that I never go anywhere where I might actually meet someone. Just wanted to make it clear that there’s a price to pay for determination to carry on!”

This patient was making tremendous efforts to stay in work as she valued it and elsewhere she discussed avoiding the stigma of not having a job. The social norm that work is good influenced her choices, inhibiting her from living within an illness narrative, which may be positive as she retained her job. However, she also appeared to be suffering socially and physically, and discussed feeling stigmatised by colleagues who viewed her as less capable than themselves, despite her great efforts to work full-time.

Other patients discussed how they had eventually taken time off or given up work because of the impact on their families of their being unable to do anything else at all, and that their families had encouraged them to stop work. In such circumstances, taking sick leave was seen as the correct decision:

“What could I possibly do 9-5 that’s as important as giving my mum her life back?” [patient 1]

When work is physically exhausting, when such powerful emotions attend consultations, and when patients’ families want sick leave, it is unsurprising that patients may be unable or unwilling to stay in work, whilst agreeing in principle that work is good for us.
All doctors agreed that appropriate work is beneficial to almost everyone e.g. GP 1 stated:

“Well I don't think any doctor would disagree that work is good, would they?”

However, set against this were two main factors. The first was that all GPs, in line with patients, felt strongly that there are many provisos to the notion that work is good for our health and well-being, which are not being considered in current rhetoric and policy, and which often preclude people from being able to work. GPs felt unable to accept that work is good for many of their patients, as patients’ working environments were frequently characterised as stressful (primarily due to working relationships breaking down, and recession survivors having to do more with no extra support). Many GPs commented that some patients’ jobs are badly paid, of low status, have poor terms and conditions and can be perceived as a causative factor in patients’ ill health. GPs felt they knew these things from patients’ reports, their own local knowledge and the media; such triangulation gave GPs confidence that most patients who reported difficult working conditions were not exaggerating. All GPs discussed how if they felt a patient’s work situation was challenging, they would be more inclined to sick-list that person:

“I mean most of the time I think work can be therapeutic - it’s better to get back to work and be normal. But for some people, work is the issue, so then I write them a sick note” [GP6]

and many GPs commented on the lack of good jobs in the current economic climate.

Secondly, most GPs felt subject to norms of sympathy, which made it difficult to encourage a particular patient sitting in front of a GP to return to work if the patient was wary or unwilling. One GP maintained:

“If people with chronic illnesses can be normal, it really helps; having a job is a normal thing to do…[but] I’m soppy soft” [GP6].

This GP explained that it was hard for them to persuade someone to return to a job if they did not want to, whether or not that job seemed to have broadly positive or negative working conditions attached. This GP was very concerned about damaging GP-patient relationships; all GPs commented on the importance of such relationships, although some were more willing to encourage, and if necessary challenge, patients about returning to work, than this particular doctor.

All the above factors made nearly all GPs feel that time off work can be genuinely helpful for more patients than the Government would like to admit to. However, all GPs were aware that after a period of time off, it is very difficult to return, and were keen to avoid that happening to their patients. They felt that negotiating when to return to work often therefore needs careful consideration, and that they were not going to bow to perceived Government pressure to return more patients to work more quickly if they genuinely did not think it was in a patient’s best interest.

7.4b Will the new fit note help sickness certification consultations?

All doctors were aware of the introduction of the fit note but none had fully read the accompanying electronic training materials as they said they did not have time. Whilst most thought work and health are linked, hence considered patients’ work status an important part of the doctor’s role, they emphasised that as general practitioners they are “bombarded with things to do all the time” [GP1] and there was tension between being a good generalist and being able to keep up with specialist areas:
“we’re cross...about all the new things we have to do. This is a tiny part of what we have to do” [GP10].

Return to work was seen as a specialist area; although it applies to many patients’ circumstances, doctors were still worried that they do not have OH knowledge to complete the fit notes helpfully – even doctors with OH training felt this, as their training had sensitised them to the differences in similar sounding workplaces. Only three doctors were aware of the work, health and well-being training on offer from the RCGP; one had attended and felt it had greatly assisted his understanding of how important work is for health. However, when told about the training, many GPs said they were just too busy to attend, and wanted on-line training that they could work through as and when they had small pockets of free time.

A minority of patients was unaware of the introduction of the new fit note, even if they had been issued one:

“it was a sick note but it was different, it was bigger and it has a few boxes to tick with gradual return to work, that’s the one?” [patient 6].

When the fit note was discussed, all patients agreed with the concept that good work is good for us and that one does not have to be 100% fit to return to work but whilst some were happy to apply this personally, others were worried it would pressurise them to return to work more quickly. As well as some participants having very different views from each other, individual doctors and individual patients expressed ambivalence about the fit note within their own personal views, discussed below.

Both doctors and patients experienced contradictory feelings about the fit note in several ways. Most doctors thought its rationale was excellent as they agreed that appropriate work is good for many patients and the great majority liked:

“the positive spin on the fit note as they’re looking to see what patients can do rather than what they can’t and that is a really positive message” [GP8].

Doctors stated they agreed one does not have to be 100% fit to return to work and thought the new design would prompt them to write more nuanced comments concerning capacity:

“As ‘phased return’ is already written out for me, I have found I am expanding my words and putting in more detail and saying things like ‘Phased return to work, needs to start with coming in from 10am to 3pm 5 days a week for the first two weeks’” [GP10]

Some doctors also liked the note as they perceived “it would put the onus on employers” [GP6] thus relieving them of some of the role conflict they commonly experience in sick-listing. However, doctors also discussed extremely inconsistent responses from employers, which they doubted whether the fit note alone would change, hence they were sceptical that much of the role conflict in sickness certification would disappear. For example, several doctors commented that whilst they were on board with more proactive approaches to return to work, employers often only wanted someone back who they perceived was fully fit:

“I think I understand what it’s about but I don’t think employers do…this ‘rules is rules’ business, HR [Human Resources] say you are not allowed to come back unless you are 100% fit, we have this discussion a lot when I am trying to get people back to work” [GP6]
This GP and several others had even had fit notes returned to them from employers who said they would not accept a fit note but

“would like a sick note which states she [the patient] is not fit to work instead please” [GP6]

as the employer would not accept the doctor’s opinion that the patient could do amended duties. Doctors were frustrated by this lack of employer engagement as they felt it was not in the patient’s best interest and also rendered the doctor powerless.

Regarding patients’ views on the fit note, some agreed with GPs that its rationale was positive and design helpful as they thought it would give out stronger and more positive messages to their employers about what they could do:

“my employers will see what I can do more clearly…I’m hopeful this might help me get more targeted support…I need some steps [to reach higher shelves] and then I can do more, so maybe my GP can say that, or maybe my boss can amend my duties a little bit” [patient 28].

Patients also had a perception that employers might be more likely to act on GPs’ advice, as the form encouraged doctors to write more details than on a sick note, although most GPs had not experienced this.

A minority of patients did not perceive that the fit note would make any difference to them e.g. patient 5 said:

“I don’t think it would have made any difference, because they both [my GP and employers] knew me well enough to know that I would go back as soon as I could.”

He felt that as he had a good relationship with his bosses and GP, and anyway wanted to return to work as soon as possible, the fit note made no difference to how his sick-listing was handled. Some patients who did not have such positive relationships with employers discussed how they would “dance round” the fit note’s recommendations [patient 14] although others thought it might make workplaces “sit up and take notice”[patient 19].

Some patients felt threatened by the fit note’s change in focus as they saw it as a way to coerce them back to work before they felt ready:

“I think at some point it says, ‘you may be fit for taking some …work’, yeah, I think, when my GP had recommended that initially, that I may be able to do some work, I felt he thought maybe my condition was not serious enough because it was absolutely impossible to actually do anything.”[patient 14]

However, doctors felt that the note’s emphasis on capacity rather than incapacity would be useful in cases when they were meeting resistance from patients who they thought should be at work:

“I’m generalising and it’s not fair but generally they [chronic pain sufferers] are a certain type of patient and they are quite difficult to manage. This note might help with that because it makes us focus on what they can do, not what they can’t”[GP3].

The fit note was thus welcomed in principle by all doctors and most patients but the findings suggest that there is still much potential for conflict in the consultation. For example, one patient said:
“It felt that I was actually putting it on, it being ticked ‘you may be fit for work taking into account the following advice’” [patient 20].

The same patient was angry that, as she perceived it, her GP had missed an opportunity to sign her off fully to begin with, before beginning a slow return to work process, and although she liked the idea the fit note would assist her employers, she blamed the GP for mishandling her sick-listing:

“If the new ‘Statement of Fitness for Work’ was available and filled out correctly when I first became ill, perhaps I would be still working and not ready for the scrapheap” [patient 20]

As with all the findings presented here, an important issue was that it was composed of participants’ accounts, as actual consultations were not observed, so it is unknown how this particular patient’s doctor viewed the same situation. It was clear from this patient’s transcript that she had a combative relationship with her GP that she did not think fit notes would improve.

Many patients said that the change from sick to fit note did not greatly change their GP-patient relationship but it did reposition how they saw the state:

“They are putting the emphasis on the fact that people who go into doctors saying that they’re not fit for work are skiving. They’ve changed the premise from ‘we trust you’, to ‘we don’t trust you’.”[patient 9]

Some patients saw GPs as agents of the state, so thought doctors would be under pressure not to sick-list which worried them and set the stage for potential doctor-patient conflict.

Doctors did not think the fit note would fundamentally alter the fact that they are the patient’s advocate, so the need to preserve doctor-patient relationships was still paramount:

“'I think the fit note system, the return to work negotiations should be patient/employer led, rather than the doctor, because we are very precious about the doctor-patient relationship'”[GP7]

Doctors did not think it would change the fact that there are not enough “nice” jobs around [GPs 1, 9] or the fact that, understandably, patients’ motivation to return to poorly paid and structured jobs was low. Patients agreed with the note’s being unable to “magic up any more decent jobs”[patient 21].

Some GPs were worried that they have been targeted as the key agent of change to reduce sick-listing and would be unfairly blamed if this does not occur:

“it’ll be our fault if we can’t change how we handle our patients. But what if there are no good jobs for them, and it takes ages to get referrals through [to specialist pain or rehabilitation services]? [GP4].

Most participants were sympathetic to the challenges of changing societal views and concurred with GP2:

“we need some kind of more fundamental cultural shift, GPs, employers, employees, the whole system”.
Most patients agreed that there needs to be cultural shift to achieve acceptance that good work equates to positive health outcomes. However, reflecting their more immediate concerns, every patient discussed being criticised for suffering a pain condition that may be invisible or visible intermittently, and how we need societal shift around not judging on appearance:

“I think you are going to have to have a major societal change in its attitudes to everything, not just pain. Because people just base assumptions on colour of skin, the way we look. This is a good starting point but it just won’t work on its own”. [patient 22]

Doctors in particular, whilst critical of some aspects of Government policy, also discussed how hard it is to embody complex sickness certification interactions within a paper document:

“But I mean if you were there in the Department of Work and Pensions is it, or whoever’s designed the note, what would you put on a single piece of paper, I mean what can you do on a single piece of paper. It needs some kind of more fundamental cultural shift.” [GP11]

Patients also discussed the gap between what may be written on paper and what actually happens:

“when I left the company, I had to sign this form to say that they had endeavoured to alter my duties to suit but it wasn’t possible or practicable but, in reality, it never happened” [patient 8]

7.4c Summary: a step in the right direction

In summary, the fit note was broadly welcomed by doctors and with greater ambivalence by patients. Both sets of participants suggested that it might improve stakeholder communication, hence could be useful in consultations when patient and GP were agreed on a course of action. Patients who felt in conflict with their doctors did not think the fit note would affect this, whereas doctors felt more hopeful that the fit note would assist in difficult consultations by repositioning the focus on capacity rather than incapacity. However, all parties were worried that the fit note and associated training around work being good for us are insufficient to bring about cultural shift, and that external factors, such as appropriate jobs being available, and employers being amenable, were crucial. As the recession was making the notion of creating more fulfilling jobs a very challenging one, both doctors and patients positioned employers' responses to the fit note as of central importance. This relieves some of the tension in the doctor-patient relationship as it gives it an external focus.

Conclusion

The non-specific nature of chronic pain sometimes made sick-listing straightforward as doctors erred on the side of caution and signed patients off. Most patients accepted this although some struggled as it altered their sense of resilience. However, in most cases, the unexplained nature of chronic pain made sick-listing more challenging for doctors and patients than for straightforward conditions with evidence-based treatments and recovery timelines. This is because it highlighted the negotiation processes between stakeholders, foregrounding how much doctors listened to and trusted patients’ accounts, and different conceptions of what was best for the patient. Patients aspired to enact pain so GPs understood it but this was challenging, and led to stigmatisation if doctors did not want to sick-list a patient whose pain made them want a sick note. Frustrated expectations undermined the social order of the clinic, creating tensions that were problematic to manage. Sick notes only partially restored doctor-patient roles, so only partially reduced the challenges of the sick-listing consultation. Participants did not think that the
Government’s training programme on work, health and well-being, or the new fit note, would solve these difficulties, although their positive tenor was welcomed. Half of the patients in this study needed sick notes for benefits; the other half for work. These patients discussed how employers’ responses to chronic pain, and their willingness and ability or otherwise to make workplace adaptions, affected what patients wanted out of the sick-listing general practice consultation. Doctors’ responses to what patients articulated about employers also affected the capability decision. It was therefore decided that the next empirical study should examine how employers and employees invest the sick-listing and return to work processes with meaning, and whether they think the doctor-patient axis influences them or they it. Chapter eight reports the research design for this study, and chapter nine the results.
Chapter Eight: Methodological Details of Second Empirical Study: Interviews with Employers and Employees

Introduction

Chapter six is the main methodology chapter which justifies the epistemological and ontological position adopted by both empirical studies, as well as the research design for the first empirical study with doctors and patients. This chapter reports the specific details of the second empirical study, with employers and employees.

There is evidence that sick-listing decisions are influenced by the GP’s and patient’s perceptions of how the patient’s employer will respond to the issuing of a sick note (see the literature review reported in chapter four). This conclusion is supported by findings from study one, which also indicated the importance of exploring the employers' perspective on sickness certification. For these reasons study two addressed the employer-employee axis. Although exactly half of the patients interviewed for study one were employees, the other half were receiving sick notes to enable receipt of incapacity benefits, hence were not in work. Also, study one focused on doctor-patient interactions, whereas study two examines employees’ experiences of negotiating sick leave within the workplace. I also wanted to explore managers’ experiences of handling sick leave for people with chronic pain, including whether managers are influenced by their understanding of employees’ sick-listing consultations and how they respond to medical statements.

The chapter now explains and justifies the sampling decisions made, inclusion and exclusion criteria, how participants were recruited, their salient characteristics, how data were collected and analysed and the University ethics and R and D approvals gained. In summary, the research design comprised qualitative interviews with 13 employers and 13 employees who were recruited nationally. Ten of the informants in each group worked for different employers and had no connection with each other, but the remaining three participants in each group were deliberately recruited as employer/employee dyads, i.e. the employee and their line manager were both recruited in three cases, and although they were interviewed separately, both parties were aware that the interviews would focus on their joint involvement in the same case. This obviously raised ethical issues which are discussed in section 8.8. Semi-structured interviews were conducted with each person individually, some face-to-face and others over the telephone. These were audio-recorded and the data were analysed using GTMs.

Research questions

As established in chapter four, the way in which we consider how the employer-employee axis fits into sickness certification needs to allow the concepts of roles, power, status and conflict to be entertained. Therefore, the research questions pertinent to this dimension were designed to mirror the doctor-patient ones in terms of considering how people construct meaning in social interaction:

- What are employers’ and employees’ aspirations and expectations regarding sick leave for chronic pain and return to work?
- Do employers and employees think the GP-patient sick-listing consultation influences workplace management of sick leave and return to work?
- Do employers think they can, or should, influence the GP-patient sick-listing consultation?
- Do employees think employers and workplace characteristics can, or should, influence the GP-patient sick-listing consultation?
- Has the fit note changed employers’ and employees’ sick leave and return to work experiences?
8.1 Sampling and recruitment

I used purposive sampling, in which informants are selected because they have attributes or experiences that make the topic of the research particularly salient to them, and are therefore more likely to generate rich data that will inform the development of theory (Green and Thorogood, 2004; Charmaz, 2006), see chapter six for discussion of the principles behind the sampling strategy.

GTMs require data to be collected and analysed until saturation occurs, i.e. until no new theoretical insights into analytical categories develop. I used the same method of constant comparison as before, from Charmaz (2006): her questions made me refine my analysis by successive comparisons of data, then codes, until I could not see any new conceptual relationships. As an example of how I considered saturation, most employers produced data which I coded as “feeling tension between the employee’s and business’s needs”. The data were not saturated in this category until I had considered how each employer felt about and acted on this tension i.e.: how it affected their sense of themselves as a boss; as someone who was also being managed from higher up; and how it affected their explanations and justifications of their actions. Table 8.3 below gives further details and examples of all parts of the data analysis process. Guest et al. (2006) provided evidence-based guidelines that 12 interviews per group of protagonists can lead to thematic saturation for data generated from qualitative interviews. I judged saturation had occurred once 13 employers and 13 employees had been interviewed.

8.1a Inclusion and exclusion criteria

Inclusion criteria for participants who were managers:
Managers had to:
- Be 18 years old or over.
- Be able to give informed consent.
- Have some experience of managing sick leave for an employee with chronic pain. This was assessed simply by asking them on the information sheet if they had such experience. The information sheet defined chronic pain as pain that lasts over three months, and may involve acute episodes and recurrence as part of its fluctuating nature. The information sheet stated that if the employee had other symptoms or conditions which were more important in terms of how their working life was affected they were unsuitable for this study.

Exclusion criteria for participants who were managers:
- People who could not understand verbal or written English, or who had special communication needs, as there was no budget for translation or interpretation. Participants were judged unlikely to respond to the process of the researcher negotiating access if they had insufficient English to understand this.

Inclusion criteria for participants who were employees:
Employees had to:
- Be 18 years old or over.
- Be able to give informed consent.
- Be in full or part-time paid employment (including those on sick leave).
- Have had a sick note (or the new fit note) for any length of time in the past year. One reason for sickness certification must be that they have, or had, chronic pain i.e. experienced pain in any part of their body that lasted for over three months.

Exclusion criteria for participants who were employees:
- People who have chronic pain, but also have other symptoms or conditions which they felt were more important in terms of how their working lives are affected.
People who could not understand verbal explanations or written information in English, or who had special communication needs, as above.

8.1b Recruitment of participants

I aimed to recruit participants from different-sized organisations as they are likely to respond in different ways to sick leave due to their differing resources: usually, only large organisations have Occupational Health departments (Black, 2008). I used the European Union Commission’s definitions of organisation size: large organisations have 250 and over staff members, medium 50-249, small 10-49 and micro 1-9 (EUC, 2003). The two different recruitment methods described below targeted different sized companies. It was easier to recruit from large and medium companies than small and micro. It is impossible to say from this study if that was because larger companies tend to have staff dedicated to managing sickness absence as only three of the twelve people recruited from larger companies had formal HR roles (see table 8.1 below, for employers’ characteristics).

I wanted to explore management of sick leave from the perspectives of employees and employers within the same organisation, so sought to recruit some employer-employee dyads who had experienced managing, or being on, the same episode of sick leave. Hence managers were offered the opportunity to make employees aware of the study, as described below. Employees who were directly recruited without managerial input could also suggest their bosses be interviewed. However, I was concerned this may occasion only positive manager-worker pairs coming forward (although in fact it did not, as discussed in the results chapter). Therefore I also planned recruitment methods which were likely to result in some unpaired participants. Three pairs were recruited, two initially via the employee and one via the manager.

I used two recruitment methods, one in person and one online. Firstly, I made contact with many South-West employers at two Knowledge Escalator days in 2010, part of the University cross-departmental Work, Health and Well-being Research Group. These were meetings between academics and business people from across the South-West region, designed to encourage knowledge transfer and R&D collaboration. Access was negotiated in principle over a series of meetings with managers in several large organisations, two of which subsequently withdrew. Once access was agreed in principle, managers were given the participant information pack (appendix fifteen), and a brief document explaining how access to the company would work, highlighting confidentiality (appendix sixteen).

Once access had been agreed with a manager, they could permit me to approach non-managerial staff. For example, at one organisation, the Head of Human Resources consented to be interviewed and agreed I could offer the study information pack to all employees. In this particular instance, she wished the letter to have her name on, having agreed its wording. However, I also wrote a letter to managers and employers coming directly from me, for other organisations who may have preferred that format, obtaining ethical approval for both letters (see appendices seventeen and eighteen).

The second, on-line recruitment method was that I negotiated approval from Bath Chamber of Commerce to target SMEs and micro-organisations, sending a study flyer to their ezine (appendix nineteen). These pain charities also displayed it in March and April 2011:

- Pain support: [http://www.painsupport.co.uk](http://www.painsupport.co.uk)
- Pelvic Pain: [http://www.pelvicpain.org.uk](http://www.pelvicpain.org.uk)
- FMA UK: [http://www.fmauk.org](http://www.fmauk.org)
- Backcare: [http://backcare.org.uk](http://backcare.org.uk)
Once potential participants had received a study pack (composed of the study information sheet with two attached consent forms, one to return to me and one to keep for their records, see appendix fifteen) it was up to them to decide whether to participate, to contact me if they had any queries or simply complete and return the consent forms. No one had any queries, so once consent forms were returned to me, I contacted participants to arrange an interview time. There was no screening process necessary for this study other than that I double-checked with participants at the point of arranging the interview that they met the inclusion criteria, which were stated in the information pack. The recruitment flowcharts below give relevant details:

*Figure 8.1: Flowchart of employer recruitment*
I recorded employers’ characteristics likely to be important for analysis, by asking brief questions at the beginning of each interview (appendix twenty); this straightforward opening also helped build rapport. I recorded the type and size of organisation, employers’ job titles, and how long they had been in that role. I recorded their gender and the number of people they managed. Data from Study 1 produced by patients still in work suggested this could be important, as small teams highlighted the effects of interpersonal relationships. I recorded whether participants were recruited via the internet flyer or via the Knowledge Escalator days: Law (2012) showed that recruiting people oneself face-to-face could change data collection as rapport may be already partly established via the recruitment process. Finally, I recorded whether interviews were face-to-face or over the phone, as this dual method has implications for what is said in interview, so transparent recording of the data collection medium was essential. Rubin and Rubin (1995) raised concerns that telephone interviews are inferior to face-to-face for fostering rapport and recognising subtle nuances of communication but Welsh et al. (2012) argued that they can assist interviewees’ comfort with discussing potentially sensitive topics. The discussion chapter returns to this point. Summary data of the employers’ recorded characteristics can be seen in table 8.1 below (this is displayed rather than risking compromising anonymity by showing individuals’ data).
Table 8.1– Summary data of recruited employers’ characteristics (n = 13)

| Gender        | F = 4  
|              | M = 9  |
| Part of a dyad? | 3 yes  
|              | 10 no  |
| Type of organisation | Schools (3)  
|              | Universities (2) |
|              | Airline (1)  
|              | Army (1)  
|              | Health and safety consultancy (1) |
|              | Insurance (1)  
|              | Library (1)  
|              | Manufacturing (1) |
|              | NHS (1)  
|              | Retail (1)  |
| Size of organisation | Mc = 1 |
| 1-9 micro (mc) | S = 0  
| 10-49 small (s) | M = 5  
| 50-249 medium (m) | L = 7  
| 250+ large (l)  |  |
| Profession or job title | HR manager = 3  
|                          | Line manager = 10  |
| Years in role* | Mean 7.69 (range 2 - 15) |
| No. people managed* | Median 9 (range 4 - 2,587) |
| Recruited by Knowledge Escalator event (KE) or internet (I) | KE = 10  
|                          | I = 3  |
| Telephone (T) or face-to-face (F) interview | T = 10  
|                          | F = 3  |

*The mean is reported for datasets that were normally distributed; the median for those which were not (see normality tests, appendix twenty-one)

I recorded employees’ characteristics likely to be important for analysis, asking brief questions at the beginning of each interview (appendix twenty-two). Some of these characteristics were the same or equivalent as for employees (i.e. type and size of organisation, job title, years worked in organisation, gender, number in team, how recruited and face-to-face or telephone interview). I also asked for employees’ chronic pain condition and chronicity in years. Finally, I asked if they worked full or part-time (and if the latter, whether due to the pain condition) or were on sick leave. Summary data of the employees’ recorded characteristics can be seen in table 8.2 below (the data are aggregated to preserve anonymity).
**Table 8.2 – Summary data of recruited employees’ characteristics (n = 13)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>F = 5&lt;br&gt; M = 8</td>
</tr>
<tr>
<td>Part of a dyad?</td>
<td>3 yes&lt;br&gt; 10 no</td>
</tr>
<tr>
<td>Type of organisation</td>
<td>Schools (3)&lt;br&gt; IT services (2)&lt;br&gt; NHS (2)&lt;br&gt; Airline (1)&lt;br&gt; Army (1)&lt;br&gt; Civil service (1)&lt;br&gt; Insurance (1)&lt;br&gt; Nuclear decommissioning (1)&lt;br&gt; University (1)</td>
</tr>
<tr>
<td>Size of organisation</td>
<td>1-9 micro (mc): Mc = 0&lt;br&gt; 10-49 small (s): S = 1&lt;br&gt; 50-249 medium (m): M = 1&lt;br&gt; 250+ large (l): L = 11</td>
</tr>
<tr>
<td>Profession or job title</td>
<td>Various:&lt;br&gt; Teacher (2)&lt;br&gt; Academic (1)&lt;br&gt; Administrator (1)&lt;br&gt; Behaviour support assistant (1)&lt;br&gt; Contract manager (1)&lt;br&gt; Executive officer (1)&lt;br&gt; Major (1)&lt;br&gt; Manager (1)&lt;br&gt; Nurse (1)&lt;br&gt; PA (1)&lt;br&gt; Software developer and engineer (1)</td>
</tr>
<tr>
<td>Years worked for organisation*</td>
<td>Mean 13.92 (range 3 - 31)</td>
</tr>
<tr>
<td>No. in team*</td>
<td>Median 6 (range 2 – 48)</td>
</tr>
<tr>
<td>Works full-time (FT) part-time (PT) or on sick leave (SL)</td>
<td>FT:9&lt;br&gt; PT:2&lt;br&gt; SL:2</td>
</tr>
<tr>
<td>Years with pain*</td>
<td>Median 4 (range 0.75 – 15)</td>
</tr>
<tr>
<td>Chronic pain condition (some Participants had multiple morbidities)</td>
<td>Fibromyalgia (5)&lt;br&gt; Back (4)&lt;br&gt; Joint hyper mobility syndrome (2)&lt;br&gt; Osteo-arthritis (2)&lt;br&gt; Sciatica (2)&lt;br&gt; Neck (2)&lt;br&gt; Hip (1)&lt;br&gt; Knee (1)&lt;br&gt; Spine (1)&lt;br&gt; Undiagnosed general (1)</td>
</tr>
<tr>
<td>Recruited by Knowledge Escalator event (KE) or internet (I)</td>
<td>KE = 7&lt;br&gt; I = 6</td>
</tr>
<tr>
<td>Telephone (T) or face-to-face (F) interview</td>
<td>T = 11&lt;br&gt; F = 2</td>
</tr>
</tbody>
</table>

*The mean is reported for datasets that were normally distributed; the median for those which were not (see normality tests, appendix twenty-one)
8.2 Data collection

I chose semi-structured interviews for data collection as they facilitate flexible responses to talk, helping to elicit rich data (Denzin and Lincoln, 1994). I developed interview questions around key themes designed to explore the study objectives and to elicit how participants invest their experiences with meaning, in line with the symbolic interactionist approach.

For employers, these were:
1. Experiences of managing sick leave for chronic pain conditions, including their own management of it, within the context of organisational structures, and its effect on them and their team members
2. Whether they think employers and employees affect negotiations with a GP about sick-listing
3. Whether they think doctor-patient sick-listing negotiations affect how the workplace manages sick leave
4. Knowledge, understanding and experience of the fit note

For employees, these were:
1. Their experience of sick leave for chronic pain: an overview of their condition and how it affects their working life
2. Whether they think employers affect negotiations with a GP about sick-listing
3. Whether they think doctor-patient sick-listing negotiations affect how sick leave is managed in the workplace
4. Support or otherwise from employers and colleagues
5. Knowledge, understanding and experience of the fit note

Appendix twenty shows the full list of questions for employers; appendix twenty-two for employees. I did not write down the interview probes on the schedules as I had for study one. Although these were useful to refine data collection, they were common sense elaborations and I was comfortable without them. I carried copies of both sick and fit notes to use as prompts for face-to-face interviews, which could not be done over the telephone (few study one participants wanted to see these but they had been useful in some instances). I did not pilot the equipment this time, as it was the same as before, but I did pilot the questions on two employers and two employees, covering both face-to-face and telephone delivery. Nothing substantive was changed although I did add a second, explanatory sentence to the first question of the first key topic in both schedules. These questions required participants to reflect on a period of sick leave and were quite challenging as openers. Yet the pilot showed that asking for this narrative helped people settle into the research process and gave me many points to come back to. As the interviews were semi-structured, I was able to alter the order and wording of questions in response to participants’ answers. Patton (2002) noted that the collection of rich data involves writing contemporaneous field notes. I wrote brief notes on every interview as soon as it finished, recording particular emphases I felt had been expressed.

Interviews lasted approximately 40 minutes and all were one-to-one. All participants were given the option of being interviewed face-to-face or over the phone. Participants were mainly located in the South-West due to the regional recruitment methods, although some worked further afield as they found the study via South-Western contacts or the internet. Ten employers preferred the convenience of being interviewed by phone; three preferred face-to-face. I went to two workplaces and the third interviewee came to a research space at the University. Eleven employees preferred to be interviewed by phone and two in person. I went to the workplace of one and I arranged a neutral, local venue for the second, as requested.
Interviews took place from January 2011 – April 2011, following introduction of the Fit Note in April 2010. Some participants still discussed the sick note, as they were encouraged to reflect on experiences over the past year.

8.3 Data analysis

All interview data were transcribed using exactly the same process as the previous empirical study as this had worked very well. I knew the data well, as I had conducted all of the interviews, and could recall many details of the experience, including particular phrases and tones of voice etc. Prior to coding, I invested considerable time immersing myself in the data by reading all transcripts, and using my field notes to check my recall of nuances.

The data analysis strategy was informed by techniques drawn from GTMs (Charmaz, 2006). I carried out initial and focused coding. To give a reminder of the process, and a flavour of the findings, gerunds were used for initial coding as they assist in gaining the insider’s viewpoint. Gerunds for employers’ data included “struggling to meet fit note recommendations” which became important for considering the gap between the positive theory behind the fit note versus real life implementation problems. Some initial in vivo codes proved analytically useful, hence were retained, including “my boss tries to help but her heart is not in it”. This encapsulated some important issues around how employees felt judged even when what were meant to be supportive interventions were offered, versus managers feeling frustrated that their efforts were not fully appreciated.

As for study one, I carried out initial coding for half the transcripts, then one research team-member took uncoded copies of four of the transcripts I had done (and relevant field notes) to do initial coding himself. We then met to discuss our coding, finding broad consensus was quite quickly reached. Once we had reached consensus, I finished the initial coding of the remaining transcripts, then completed all focused coding alone.

For focused coding, the most useful initial codes were tested against the data to decide which made most analytic sense. The axial coding questions by Green and Thorogood (2004) used previously were employed. They facilitated weaving the dense texture of relationships between categories required by GTMs (Charmaz, 2006). Special attention was paid to deviant cases to ensure a comprehensive, credible account of the data (Green and Thorogood, 2004). For example, every employee but one had experienced some elements of conflict with line managers, concerning how fit note recommendations were implemented, then phased out. The one employee who was wholly positive hence appeared to be a deviant case, as her fit note recommendation for reduced hours was smoothly implemented by her organisation and accepted by her. On reconsidering her data, it was apparent that one reason for the lack of conflict was that she had willingly made her reduced hours permanent, since she was financially able to do so. She explained she had avoided the stress of rebuilding her hours back up to full-time, and that her company was very happy that she was now predictably working flexi part-time hours, which she could manage, rather than unpredictably staying off work whenever her pain became too bad. Hence, she was deviant in the sense that she experienced little conflict, and she framed her experience very positively.

Throughout the coding process, I wrote memos, as recommended by Charmaz (2006): these had been useful in study one to compare codes and develop analytical categories. Nvivo 9 was used to manage the analysis.
Table 8.3: Summary of data analysis methods with examples (study two)

<table>
<thead>
<tr>
<th>Data analysis methods</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial coding:</strong> word-by-word or line-by-line study to generate preliminary codes.</td>
<td>&quot;the other thing is, which is probably part of my own… character really is that I can get really… drawn into something and then… I'll… just carry on… I'm meant to have lunch breaks but most of the time I don't&quot; [employee 2]. I coded this as &quot;showing I am resilient&quot;, using the transcript, my knowledge of conducting the interview and my field notes.</td>
</tr>
<tr>
<td><strong>Field notes:</strong> contemporaneously written by the interviewer, used to check for nuance.</td>
<td>This participant spoke hesitantly, often sounding despairing. I noted at this point, however, that her tone of voice became much stronger, even defiant, as she explained how she tried to do her best in what she perceived as difficult working conditions. As she continued, it was clear that it was crucial to her to be seen to be doing her best, by her, by her boss and even by me. Thus the gerund &quot;showing&quot; was an important choice for the initial code, and I felt she was trying to display resilience.</td>
</tr>
<tr>
<td><strong>Inter-coder agreement:</strong> a different research team member coded a section of data using transcripts and field notes. We then met to discuss our interpretations until broad consensus was reached.</td>
<td>&quot;the other thing is, which is probably part of my own… character really is that I can get really… drawn into something and then… I'll… just carry on… I'm meant to have lunch breaks but most of the time I don't&quot; [employee 2]. The re-coder coded this as &quot;defending my character&quot;. He had access to the field notes but not the recording or experience of having interviewed the participant and felt these data represented a more defensive point than I. When we discussed these codes, we thought both pertinent in trying understand different aspects of meaning. We agreed to combine them as &quot;defending character by showing resilience&quot;. This became part of the focused code &quot;sense of self is altered by sick leave&quot;.</td>
</tr>
<tr>
<td><strong>Memo writing:</strong> to compare codes and develop analysis. Inductive building of theory.</td>
<td>Memo: &quot;defending character by showing resilience&quot; as a subcategory of the focused code &quot;sense of self is altered by sick leave&quot;. Both employers and employees experienced shifts in self-image as a result of managing, or being on, sick leave. This was more pronounced for employees, who discussed the effects of incorporating &quot;unable to do what I used to&quot; in practical and psychological terms (worries about effects on colleagues, financial issues for part-timers, how they would be viewed by co-workers and family members). Some employers also struggled to reconcile their views of themselves as a fair boss and a fundamentally decent person, with having to consider business versus employee needs.</td>
</tr>
<tr>
<td><strong>Focused coding:</strong> the most useful initial codes were tested against the data to see which made the most analytic sense. Deductive i.e. theory of &quot;sense of self is altered by sick leave&quot; being a useful analytical category, with &quot;defending character by showing resilience&quot; as a subcategory, tested against the data.</td>
<td>&quot;defending character by showing resilience&quot; was tested against other data segments and fit in many cases. For example, Employee 9 stated &quot;the doctor had said to me, I'll give you a note to reduce your hours at work. I said no, no, I don't want any of that, I just want pain medication…I just wanting something to be able to allow me to continue doing what I am doing&quot;. As recommended by Charmaz (2006), I considered the interactional strategies and context of data. In this case, the participant worked despite severe pain until her supervisor initiated discussions which influenced her decision to see her GP. He recommended various things including time off. The participant found this hard to accept and drew attention to her difficulty incorporating it into her self-image of a physically and mentally strong worker. She was not defending her character against an unsympathetic boss but against her own view of herself. The initial code &quot;defending character by showing resilience&quot; became part of the focused code &quot;sense of working self is altered by sick leave&quot; as the latter was able to account conceptually for so many data.</td>
</tr>
</tbody>
</table>
In short, the analysis was carried out according to constructivist GTM principles. It was done sequentially and iteratively, building up theory from empirical data by exploring thematic relationships, and also testing theory against data to give a rich account which remains grounded. The results are presented in the following chapter, and their relationship to the literature discussed previously is more fully considered in the discussion chapter (ten).

8.4 Ethical approvals

Full consideration of the project was required by SREAP, the School Research Ethics Approval Panel of the School for Health, University of Bath. All appropriate documentation was submitted in November 2010 and ethical approval awarded with no amendments. The study information pack explained to participants how the following ethical issues would be managed:

Anonymity

I needed names and signatures on the consent forms, so anonymity was not possible. However, once participants had provided informed consent, they were given a numerical code and identified this way for the rest of the study. As I recorded the interviews, it was impossible to pseudonymise the raw data before transcribing. However, only the researchers and the ethically-bound professional transcriber were able to access the recordings. The transcripts were fully pseudonymised, so that names and any other detail or combination of details that might support identification were removed from all quotations and any writing about the study. This is particularly important as manager-employee dyads pairings from within the same company participated. As summary data on participants’ characteristics have been presented, it should be impossible for any individual to identify themselves or their counterpart.

Confidentiality

Participants were informed that confidentiality would only be breeched if they disclosed they wished to harm themselves or another, in which case this information would be passed on to a professional colleague, in line with guidance from the British Psychological Society’s Code of Ethics (BPS, 2006).

Data protection and storage

The data and transcripts are being stored on a University computer saved in a password-protected data file. The paper versions are being kept in a locked cabinet in a locked room at the University. All data are being protected in accordance with the Data Protection Act (1998) and the Department of Health’s NHS Code of Confidentiality (2003). Personal data, such as those on consent sheets, will be destroyed 12 months after the end of the study (deemed to be once the viva has been completed). Data generated, such as transcripts, will be destroyed 2 years after the end of the study. If a participant had withdrawn, all identifiable data would have been removed from the study; this did not occur.

Risks to participants

It is impossible to claim that participating in research carries no risk e.g. in this study, a participant may be daunted by considering a return to work issue. However, the study adhered to the BPS principle that when participants enter a study they should not, in so doing, increase the likelihood of coming to harm, and individuals should not be induced to take risks that are greater than those that they would normally encounter in their life outside research (BPS, 2006). The study information leaflet detailed sources of support, should any participant feel that taking part caused harm. It emphasised the voluntary nature of participation, including the option to withdraw without giving a reason at any
time. Participants could contact me should stress, potential harm, or related questions or concern arise despite the ethical precautions taken; this did not occur.

*Risks to the researcher*

I left a schedule of when and where face-to-face interviews took place and contacted a supervisor after each one.

*Informed consent*

All participants consented in writing. There were two identical consent sheets at the end of the participant information pack (appendix fifteen). Participants signed both, sending one to me and keeping one for their records.

**Conclusion**

In summary, I have justified my research methods in terms of how best to answer the research questions. I have explained how recruitment, data collection and analysis were carried out, and presented the salient characteristics of research participants. These are used in the presentation of the results, which follows.
Chapter Nine: The Employer/Employee Dimension

Introduction

The doctor-patient consultation is the focal point for the sickness certification process, providing the moment at which illness-related absence from work is ‘officially’ granted or denied. However, as study one demonstrated, this key decision is influenced by a complex web of additional factors and relationships that exist outside of the doctor’s surgery. If the patient is in paid employment, then the nature of the work, the characteristics of the job and the social relations entered into at work can have a profound influence on the patient’s attitudes towards sickness absence and on the doctor’s assessment of capacity for work. One of the difficulties in assessing the patient’s ability to work, reported in study one, is the doctor’s lack of direct knowledge of the workplace and therefore reliance on the patient’s account. However, there is little qualitative research into employees’ and managers’ experiences of sick leave for chronic pain, and particularly on whether they think managers can or should influence sick leave negotiations between GPs and patients. Study two addresses this lacuna by examining the experiences of employers and employees regarding sick leave and return to work, considering whether and how they perceive their roles interact with those involved in the GP-patient consultation. Also, the fit note was still relatively new at the time of this study (it started in April 2010 and this study was conducted January – April 2011), and one of the policy objectives behind it was to facilitate better communication between doctors and employers, so study two also provides early evidence of employers’ and employees’ experiences and expectations of this innovation. Through in-depth qualitative interviewing, I attempted to gain an insight into the following research questions:

- What are employers’ and employees’ aspirations and expectations regarding sick leave for chronic pain and return to work?
- Do employers and employees think the GP-patient sick-listing consultation influences workplace management of sick leave and return to work?
- Do employers think they can, or should, influence the GP-patient sick-listing consultation?
- Do employees think employers can, or should, influence the GP-patient sick-listing consultation?
- Has the fit note changed employers’ and employees’ sick leave and return to work experiences?

I begin by reporting employers’ perspectives, then discuss employees’ views. Woven throughout are considerations of the challenges to the workplace and employer-employee roles posed by managing sick-listing for chronic pain, and whether the policy response to sickness certification can help.

As in the previous results chapter, the exact number of people who contributed to each theme is not usually shown, as this suggests a representativeness which ignores how themes’ strengths were also expressed by different degrees of emphasis (Wenger, 1988; Gabe et al., 2002). Sometimes “[my employer]” or “[my employee]” have been substituted for phrases indicating the nature of the organisation to protect anonymity.

9.1 Do employers and employees think the GP-patient sick-listing consultation influences workplace management of chronic pain sick leave and return to work?

9.1a Employers’ views: limited power against other stakeholders and types of knowledge

Most employers thought that whilst doctors and patients negotiate whether or not sick leave should be taken, and for how long, patients had the final say:
“So she actually made the [capability] decision, not the GP” [Employer 9].

“I think the doctors will often put what the patient wants because who are they to say otherwise. Once it is written by a doctor who am I to say otherwise because it’s a professionally qualified doctor and that’s a tricky issue where it sits so where does it sit at the moment. It sits with the attitude of the patient because the doctor still issues advice” [Employer 1].

Employer 1 reported that their employee dyad discussed matters with him unlike some other employers who perceived both themselves and the doctor as powerless against the employee. Employer 1’s quotation above shows a hierarchy in which the employer was powerless against the doctor’s professional advice, so doubly affected by the power of both the doctor and patient, who may or may not be in accord.

Employers also discussed how they thought chronic pain made sickness certification “tricky” due to its possible contestability and how this privileged employee’s accounts:

“What it relies upon is the individual deciding whether or not they are fit…well, there can only be subjectivity, can’t there” [Employer 2].

As well as implying that doctors are challenged by such subjectivity and must let the patient decide, employers expressed sympathy with GPs because they thought that systemic constraints hindered them in making capability decisions. Signing someone off when they may have been better at work was seen as a result of employees seeing different doctors:

“Doctors don’t know the person well enough. And part of the reason for that I believe is because our employees, and some of them are very clever, they’ll see a different GP every time. And that’s part of the problem I believe as well. And when I was growing up and I was younger I had a family doctor and you saw that doctor, you just don’t have that anymore. The GP is not able to see an improvement or deterioration” [Employer 6]

Employers did not feel they could do anything to change this aspect of the sick-listing system and that it led to employees remaining at home when they could have been at work.

Even employers who were sympathetic towards doctors’ difficulties were often critical of the amount and quality of communication from GPs and expressed ambivalence about doctors as a professional group. Employer 6 suggested that patients manipulate the system and that doctors are “not able” to respond properly. She added that “doctors are not my favourite people”, and criticised their completion of fit notes and OH reports (for which they are paid extra). Such ambivalence was very common amongst employers who were often frustrated that they could not access good quality information about the employee to assist with return to work processes, although some recognised that doctors faced their own professional pressures:

“The GPs will not respond at all to the employer…and I can understand it you know…they’ve got a very very busy job to do” [Employer 11]

Many employers discussed how they thought doctors varied widely in their willingness to engage with back to work issues:

“A GP that we have is absolutely brilliant…then we go to the other extreme and you get a fit note where it’s just signed and the rest is totally blank…and you think, for heaven’s
sake, so then it’s working with the employee and trying to work with the GP practice, where you keep sending them letters and letters. I even go and hand deliver it to the surgery and there’s still no response back” [Employer 13]

This quotation shows that doctors’ perceived ineptitude directly affected what this employer could do to help their employee back to work. Later in the interview, the employer complimented the employee, constructing them positively and seeing the two workplace parties in it together, struggling with poor communication from the doctor, rather than the doctor-patient dyad against the employer.

Other employers compared their professional pressures to doctors’, excusing both their own and doctors’ lack of communication and also positioning doctors as the bigger culprits:

"I think in theory the fit note should increase communication because in theory if you as a manager get this and you’re not sure what it means you should talk to an HR department and ultimately you talk to the GP and get advice. I think in reality managers, HR departments and GPs are so busy that it’s not going to happen…and doctors’ handwriting, I mean seriously, can you see people being able to read that? Yes, you do need a translator [laughs]” [Employer 4]

Black humour aside, several other employers complained that being unable to read doctors’ handwriting was a serious issue when it came to using the fit note. It meant potentially valuable information was wasted, and placed more weight on the employee’s own account, which was difficult for some self-proclaimed cynical employers:

“...I mean I always get the impression you know the joke about doctors handwriting? Well, A it’s terrible and B they are very sparing in what they write. And because of that, there you are, off you go and then you get to hear from the person which I am sure in some cases is absolutely true but in other cases it is “He [the doctor] said he has never seen anybody with a runny nose as bad as mine”. And you think come off it you know depending on the individual but those people who are of a mind to go to max are going to make it sound worse… I do sound a terrible cynic but I can’t help it I actually am” [Employer 2]

Employers reported that either the doctor, employee in their role as patient, or both, directly affected the information the workplace was given, and that managers had very little role in the capability decision. Some employers thought this lack of role was entirely appropriate, given the professionalism of the medic but others implied employees actively sought to be sick-listed inappropriately and that doctors either colluded or that systemic constraints shaped their too lenient provision of sick notes. Some employers dealt with these difficulties by accepting that the capability decision was not in the workplace arena and discounting information from GPs if they did not have any quality input from them. Employers recognised it was difficult for GPs to have a good knowledge of particular working environments, hence did not really blame them for this:

“...There isn’t the time in the system to do that. They’ve had ten minutes for that person, you know… if someone goes to Occupational Health at the point, they have twenty. Clearly they are going to get more out of that, they’ve got that awareness, they’re sat with the employee with a referral, with a job description of the job they do. Of course they’re going to be able to provide much better advice” [Employer 11]

Employers blamed GPs for not proactively getting patients back to work. Although as reported above, many employers saw the employee as the most powerful protagonist, they still felt doctors were too detached from return to work processes and that careless completion of fit notes and OH reports was indicative of this:
“I guess I am then questioning whether you know are GPs actually going through all the checks, or are they just signing a bit of paper like they were before?” [Employer 9]. “Because I tell you when I often get GP reports I send off for which we pay for and I mean it is £150 on average…And oh sometimes I just feel as if they haven’t thought about it…maybe it’s just too early days, and like I say until the GPs believe in it [the fit note] and use it effectively then I think as an employer I am not going to see any sort of real benefit” [Employer 6]

Most employers tried to use information from the GP, but found it difficult to apply in the workplace:

“Another issue is around staff’s understanding of it. And if the GP (and GPs always have done this), put things down which perhaps do not take full account of what’s happening in the workplace, or they put down things which are not reasonable adjustments for… for the department or the organisation that we’re in. There’s a real difficulty because the member of staff says, fine, oh my GP’s given me this, you know, so it must be right. And, then I will say, well, you know, actually, that might work in this and this employer, but here, because we work in this particular way, that’s not possible” [Employer 11]

This quotation illustrates the employer’s struggle to reconcile GP advice with workplace constraints, and the tension between the employer and employee that such advice can give rise to. Most employers with in-house OH departments said they valued OH information more highly than GPs’ reports as the OH department knew the workplace better. However, some employers thought GPs might know the employee in a more holistic way than OH, although most reported that general practice 10 minute slots would elicit less useful information than could be gleaned from longer, more extensive OH appointments. A few employers said they “work very closely with GPs” [Employer 13] and constructively used GPs’ information to assist in planning return to work. These positive views came from employers working in large organisations with OH departments, suggesting GPs’ information can complement companies’ in-house back to work programmes, rather than there necessarily being tension between GP and OH advice. It might be expected that smaller organisations without in-house OH departments, who have to put more effort into obtaining OH information, would value GP input more than larger organisations. No evidence was found in this study to support this, although the sample size was small.

In summary, most doctors interviewed in study one stated that the patient/employee was usually the decisive party in the sick-listing decision. Evidence from the employers mirrors this finding, with most employers sharing the belief that the employee/patient tends to be the dominant voice in sickness certification decisions. Many employers felt that doctors granted sick notes too easily, particularly for subjective conditions like chronic pain. There was some recognition that doctors face their own occupational pressures, but also a sense that medical opinion is privileged over employers’ workplace knowledge. This made it hard to challenge GPs’ recommendations, even if these were difficult to implement. Employers’ thought that more specialist OH information should be used within the sick-listing process. Some wanted to use it in combination with GPs’ advice as they valued the holism therein.

9.1b Employees’ views: power between stakeholders fluctuates

Some employees reported that their role as patient in the GP-patient sick-listing consultation was the key to the capability decision. Many employees stated that, in common with the patient data in chapter seven, they felt they knew their own capability better than the doctor and better than the employer:
“I know if I can work better than anyone” [Employee 13]

Again, in common with the patient data in chapter seven, the majority of employees reported that whilst there might be some conflict between them, their GP and the workplace, in general, they were sick-listed when they wanted to be and were able to return to work when they wanted to. Many employees reported that they, and their doctors, were able to come to an agreement about return to work and it was then a question of bringing their influence to bear on the workplace, usually communicating via the fit note. Some employees reported that their doctors were able to influence the workplace directly. For example, one commented on the symbolism of taking in a properly completed fit note and how that had helped her negotiate a smooth return to work with her managers:

“The note reflects that you’ve had a conversation with your GP, and your GP has agreed these things with you, I think this carries far more weight…than just a piece of paper that’s been stamped and signed. I know I…I certainly felt more comfortable knowing that there’d been these conversations going to my employers, because I felt I had more to tell them, more than just, oh, I’m off sick. I’m sick because the doctor says I’m sick” [Employee 9]

In this case, medical knowledge appeared to be privileged over the employee’s own account of her condition by the employee herself and, she presumed, by her employers, as she felt legitimated by the doctor’s note.

The following patient wanted to work whereas his manager was initially reluctant to have him back, until the GP communicated with the workplace:

“He [the doctor] believed that, you know, if you can do some work it’s better for you than being at home and...he was disgusted that [my employer] said they didn’t want to know. It was my first meeting with them, when he’d obviously diagnosed me... sent the sick notes in...he just said ‘I think it’s a good idea for you to do some work but we’re going to have to limit it and we know that the situation is only going to improve is when you’ve had the hip replacement’. And, that’s what he said – so he knew and he told them that, and once he told them all that information, I think they changed their tune” [Employee 1]

This shows how medical opinion not only is used by the employee to validate sickness, as in the previous quotation, but also by the doctor and employee to persuade the employer to have the worker back.

Many employees at organisations which had access to OH advice, reported that their doctors had no or insufficient influence over how sick leave periods were managed at work, as OH knowledge was viewed as superior by line managers. Some stated their doctors were “powerless” [Employee 6] to affect managers and organisational procedures. One employee who wanted to go back, and whose doctor had initially agreed she was able, said:

“I don’t think there is actually anything else he [the doctor] can do, because I know they won’t accept me back until I’ve seen Occupational Health – they’ve said that” [Employee 6].

This employee knew that there were insurance issues for the company impeding her return. However, she had to wait so long to see OH that eventually her GP kept her signed off due to her increasing anxiety over waiting. Her boss was not interviewed but other bosses commented on the frustration of appointment times taking so long that people who were originally keen to come back to work became disengaged or unable to return, and what an “unacceptable waste” [Employer 11] this was.
More positively, a few employees reported that their doctors and workplaces managed to work together; this did not appear to depend on organisational size or resource, but on the individuals involved. For example, one employee reported how he wanted to return to work but was afraid his workplace did not appreciate his suffering. He discussed how proactive and interested in work and health his doctor was. This doctor contacted the workplace, persuading them that the employee’s needs were genuine, and then convinced the employee that the workplace would be sympathetic:

“And I think the doctor was telling me that...my GP was telling me that they were trying to change it - the attitude towards people who are in pain. He said, what they are trying to do is...we get a lot of people who had disabilities and in pain but they can still go to work. He said, if they don’t, you get even more problems ... because what happens you get mental illness because you just get down and depressed and it just compounds the problem. Because the people at work are sympathetic. It’s all the better for everyone.” [Employee 1]

The employee then reported that he was persuaded by the doctor and workplace’s united front that he could and should return in a manner appropriate to his needs. This employee’s workplace accessed OH help, but the employee did not report GP-OH conflict, whereas Employee 6 above did. Employee 1 appeared to have a very proactive doctor who successfully interceded with the workplace and whose opinion was trusted.

Even those who felt they had most power in the sick-listing decision reported that pressure from the workplace influenced how the patient-GP consultation went. This could be circular as the GP-patient consultation could also influence the workplace over the same issue. For example, chapter three reported how patients wanted a diagnosis as they thought that having one would lead to treatment, hence feeling better. In this study, employees also wanted a diagnosis for the pragmatic reason that they felt a named condition assisted their workplace to understand their needs. One employee discussed how she had to fight with her GPs to get a diagnosis but did so as she knew a diagnosis would have a direct, practical effect on how her sick leave was managed:

“When it was the fibromyalgia they [the GPs she saw] were very reluctant to give me a diagnosis. Because they didn’t want me to feel that I had something else wrong with me. Of course, from a work point of view, work actually needed to know what conditions I had and what the diagnoses were and... what was going on relating to it. Once I had the diagnosis of fibromyalgia, that meant that work could give me consideration points for leave” [Employee 8]

In this instance, the workplace initially influenced GP consultations, since the patient was responding to a perceived workplace need which shaped her behaviour towards the doctor. The consultation result (i.e. the diagnosis) then affected the workplace’s management of sick leave, showing how the power dynamic between the workplace and consultation was interactional.

This section has shown the key themes emerging from the data analysis regarding whether and how employees think the GP-patient sick-listing consultation influences workplace management of chronic pain sick leave. Employees discussed that their self-reports of symptoms and appraisals of workability were key to the capability decision, although they wanted the reinforcement of medical opinion to take to the workplace, as this reduced their fears of being disbelieved. Medical knowledge was also used to persuade initially reluctant employers to take back workers. However, in other instances, it was diminished against the perceived value of OH advice, so there were contested power relations between medical and occupational knowledge. The extent to which employees felt that their employer acted upon advice from their GP, did not appear to stem from
whether the organisation had access to OH input; but rather from individuals having especially proactive doctors whose opinion they trusted. Structural issues such as long wait times impeded progress; sometimes, all parties worked together to achieve mutually agreed goals.

9.1c Summary: comparison of protagonists’ views
Both employers and employees reported that workers’ self-reports of symptoms and incapacity was key to the capability decision but whereas employers found this challenging, as employees had too much power over GPs, it appeared natural to employees. Both sets of participants reported that GPs’ opinions have considerable status, but employers felt justified in ignoring these opinions if they felt they were incomplete or impractical, although some managers wanted higher quality information to use in conjunction with OH advice. Patients were troubled when GP advice was ignored, and frustrated by OH referral times and GP-OH conflict. Employees thought that employers had more influence over how they behaved as patients in the sick-listing consultation than employers themselves did. Employees reported that if they struggled with aspects of their workplace, such as the need to give managers a diagnosis, this shaped how they presented issues to the doctor. The consultation result (i.e. the diagnosis) then affected how managers managed sick leave, showing how the power dynamic between the GP and patient within the consultation, then the patient as employee and their employer, was interactional.

9.2 Do employers think they can, or should, influence the GP-patient sick-listing consultation?

9.2a Social norms promote entitlement to sick-listing which is hard to challenge
Some employers said their workers lacked resilience, which they could not do much about:

“it’s that inability, it’s the lack of coping strategies that they have. You know I could get on my soap box but a lot of them don’t come from stable families, and you know that to me is where the lack of coping strategies start” [Employer 6]

“I’ve had lots of conversations with [name] saying ‘you know I can help you up to a point but you have to help yourself. You know, I go and walk around the lake every lunchtime because I have to go out and get some fresh air and exercise’. She doesn’t do that, you know I say ‘you have to manage it yourself, you have to go and stretch, you have to go for walks. Whatever you’ve learned, take your techniques and do it’. It all comes out very negatively which I understand is very difficult for her and she lives on her own” [Employer 9]

These quotations show managers expressing some understanding of employees’ difficulties but also frustration that workers were not perceived as helping themselves. Some employers linked similar perceptions of employees lacking resilience to their own inability to influence the professional say of the doctor:

“My ears always prick up when I hear people saying things like ‘I’m entitled to so many days sick’. Well, you’re not entitled to be sick. That would be a strange thing wouldn’t it, would someone want to be entitled to illness? I’d rather forego that entitlement. I’d rather be entitled to wellness really. At the end of the day if a person’s given entitlement, you know they’re told by the doctor to be off, there’s nothing I can do” [Employer 2]

This employer positioned himself as a negative authority figure in employees’ lives, whereas their GPs were positive, so he was never favoured over the doctor:
“in this work culture that I’m discussing there are some people who seem to have completely open dialogue and access with their doctors like they are around the doctors when anything happens. And I’ve wondered if the doctor must see that name and think ‘what now, what is it? Some minor blinking thing!’ But they will go and if the doctor says you have to do this then you have to do it. You have to do it, yes, you have to do what the doctor says, so if they sign you off, you have to stay off, and yet on the other hand if someone else gives them something else to do that’s inconvenient, like me asking them to do the stocktaking, then that authority figure is like a policeman, then that is like some kind of arsehole who is trying to impinge upon them. So their feeling of authority is kind of shaped by what the authority is saying to them and depending on the figure, the police will tell you off, doctors give you time off to recuperate”[Employer 2]

This quotation shows the employer’s view that there was a work culture of low resilience yet it was difficult to influence the GP-patient relationship as employees privileged what GPs said. This quotation also shows the employer’s view that the doctor had the power in the capability decision. By suggesting doctors thought the individual’s condition was not serious but signed them off anyway, the employer implied the medical authority colluded in malingering. Later, the employer suggested the patient has power, not the doctor:

“Well the thing is what it relies upon…is the individual deciding whether they are fit or not. Because you could send two people to see the same doctor with the same complaint and you will come up with two different cases”[Employer 2].

Whoever had the power, the doctor, patient, or both, the net result for this employer was the same: he was at one remove from the consultation and could not influence it; his authority had been usurped. Later, he suggested patients “pushed” GPs to be signed off, and used the doctor’s professionalism to cement the sick-listing in their minds. Other employers reported similar views:

“You’ll get that type of culture with people, it’s not their fault, the doctor tells them they couldn’t come in. ‘I really wanted to but the doctor said….’ I just think yes, I wonder how much the doctor said it and I wonder how much you pushed it and then you heard it from him and that qualifies it in your mind.”[Employer 1]

Chronic pain was seen as a particularly challenging condition due to its perceived invisibility and fluctuations. Some employers found chronic pain challenging and wanted tangibility:

“We don’t know what goes on at the doctor’s and how that conversation reflects what we see going on here. So an outward obvious physical symptom was quite useful. Because again everybody has a very different idea about pain”[Employer 8].

Some employers were empathetic and simply accepted the doctor’s information:

“I think you have to put yourself in their shoes. Because how would you want to be treated if that was you? You know if somebody’s in pain they are in pain and if they can’t walk properly as she [employee] couldn’t then that’s how it is…and at the end of the day she’s been certified as being off sick and that’s it and you’ve got a doctor’s note and that’s it” [Employer 7]

In all these cases, the employer positioned themselves as unable to influence the GP-patient consultation, much as many would have liked to. There was ambivalence reported about what type of influence should or could be brought to bear, i.e. whether employers could influence the original capability decision (a few thought so) and whether employers could influence how sick leave was managed, i.e. how phased returns were timed and
workplace adaptations put into practice. Most employers thought they should be able to influence these two factors as they knew the workplace better than the GP and were frustrated if they could not. Most employers thought that both types of influence were in any case linked, and that if GPs had a better understanding of the good conditions in their particular workplace, they would be less inclined to sick-list. However, this would depend on the GP taking the lead in the sickness certification decision, when in fact most employers felt that the patient was driving the decision.

Several employers had invited general practices to view their workplace, on the assumption that if doctors saw good working conditions, they would be less likely to sign someone off. Most employers found doctors were simply too busy to visit the workplace. One employer organised a successful visit but thought it made no difference to sick-listing:

“Employer 6: “We’ve just had a brand new, all-singing, all-dancing practice, opened down the road and to be fair not all our employees use it but I would say about 65% do. And we invited them to come and have a look around the factory. And they had a look at the factory and they were shocked. I don’t think some GPs had ever been in a factory. Interviewer: What were they shocked about? Employer 6: They had just made assumptions on how some things would work and how a factory, could be, I have to say, ours is very clean, tidy, they thought it was going to be black and awful. Interviewer: Has that interaction changed things? Employer 6: Well I don’t think it has to be fair. It’s disappointing to say that”

The same employer also sent “a really detailed job description” every time a sick-listed employee went to see their GP to renew sick leave, and felt that had made no difference either. She expressed frustration that there was nothing else she could do and that in her view, the sick-listing process was unbalanced: people were signed off and kept off too easily.

Only one employer out of the cohort (an HR manager) had a positive experience of involving local GPs in a project to try to change minds about sick-listing:

“We’ve started a group [local companies] and myself and the local GPs to find a way, to find common ground for best practice…if an employee or their patient is away for any length of time the stats prove they don’t want to go back to work or they can’t go back to work…it’s to stop that happening…some people can’t go back to the job that they’re doing, there is hope there may be something else in the company they could possibly be doing? And it’s to break down the barriers so every party can have a different…an understanding of how it affects them. The GP that we have, she is absolutely brilliant, and her emails after the group came across, saying it’s so enlightening, because it gave her a different outlook and perspective, that whenever they go to sign a fit note, what it is, and what is actually happening, and the consequences on the other side” [Employer 13]

It did not appear that this group included a patient representative but the quotation above shows the employer assuming that what they are were doing in this employer-GP group was good for patients: the employer’s referring to the “stats” was one of the few instances in which employers alluded to research that once someone has been off work a certain amount of time, it is very hard to return. The employer and GP appeared to be working together to prevent this; the employers felt that GPs would be less likely to sign people off if they understood the consequences for the person, as well as the business:

“GPs need to be aware of the real fantastic impact the fit note could have … I don’t know if it’s because it’s easy or if it’s through lack of training, they just tick not fit for work and actually I know they only have like ten minutes… that is so difficult. But if they just started
to think, well actually, you know, the patient could do this...and send them back for a further consultation with their employers...there shouldn't be a mistrust between GPs and employers because we are actually all working for the same aim...we are very conscious of the fact that people do sometimes need complete time away from work and they're able to rest away so it's a fine balance sometimes”[Employer 13]

This employer was clear that sometimes employees really did need to be signed off, but that this probably happens too easily. She saw the business’ and absentee’s needs as often being mutual i.e. to keep the employee in work where possible and facilitate smooth return to work when absence occurred. This mutuality for her meant that she did not need to be in conflict with doctors and could influence them to show her good intentions towards the employee. No employer reported that organisation size or length of time they had been in their role affected whether or not they thought they could or should influence GP-patient consultations.

9.2b Summary
Nearly all employers thought they could not influence the GP-patient sick-listing consultation, due to the doctor-patient relationship and social norms that allow inappropriate sick-listing. Employers reported mixed views about where the power in the capability decision lay. They reported that employees lacked resilience and used the doctor’s standing to ratify being signed off but also felt that the GP cannot trump the patient’s subjective claims regarding fitness for work. The perceived uncertain nature of chronic pain meant either employers accepted more readily they could not and should not influence GP-patient interaction or that they found their inability to do so all the more challenging. Employers recognised GPs’ gatekeeping function, but questioned it as: GPs lack workplace knowledge; there could be little evidence of physical pathology for chronic pain sick-listing; there was a suspicion GPs colluded knowingly or unknowingly with malingering. Only one employer reported working with doctors to influence their views on sick-listing so that they considered its long-term effects more deeply. This suggests employers sometimes appreciate links between work and health more than doctors.

9.3 Do employees think employers and workplace characteristics can, or should, influence the GP-patient sick-listing consultation?

9.3a Poor fit between the problems of returning to work with chronic pain and typical return to work solutions
Some employees thought employers did not believe that they were unwell, at least initially:

“And when it eventually must have just deteriorated that much...I couldn’t walk any more...and then when they realized it was genuine and the doctor was involved...and they were then very supportive and sympathetic. But I think it was that case of oh, someone is trying it on here.”[Employee 1]

This employee, and most others, thought that employers did have some influence over how employees articulated their desire or otherwise to be in work to the doctor. The employee above went on to explain that his managers did not offer practical or emotional support until they believed in his ill health. Belief was not forthcoming until something was visibly wrong, a common issue identified by chronic pain sufferers:

“the gist I get from it is, that because of the condition I have, it’s led by how I feel and what I feel I can do, which is fine for a GP...But when you come to an employer they don’t trust that” [Employee 6]
Some employees reported that as they felt believed by doctors and not employers, they privileged their GP’s views over their employer’s. However, this did not mean that employers had little effect on how employees constructed their need for time off. If managers were seen as unsupportive, employees were less likely to want to return to work, and were explicit about discussing this with doctors. For example, one employee described relief at being offered a period of sick leave after a confrontational time at work:

“at least I thought I have somewhere to go now, because at least I can go and get this note from the doctor and she was keen for me to have a break from all those problems we were discussing at my work” [Employee 12]

Employees who wanted to return to work articulated that workplace procedures affected how smoothly or otherwise returning was managed, and this was directly linked to the difficulties of managing chronic pain:

“like every time you’re off sick…you go straight back to say, got to have a meeting, got to go to Occupational Health, got to do this, and that’s not just a simple, I feel fine, I feel better, I know what I can do and can’t do, I can come back, I can say, I can come back to work – it’s not like that, because my say so won’t cover their insurance. And in a way, for me, it feels actually… it discriminates against people who have long-term chronic conditions because if you’re off because you break your leg, well that’s simple. You know, you’re off for six weeks. Ok, so the long-term absence policy starts…go back to Occupational Health – they look at your leg saying, the plaster’s off, yes she’s fine, she can go back to it fine…you can go back to work. But if you're somebody who has a chronic condition: A lot of these systems find it very difficult to deal with something that’s both chronic and fluctuating” [Employee 6]

This quotation exemplifies how current return to work practices in many organisations, entailing a linear process of phased return and the assumption of eventual full recovery, simply do not fit the fluctuating and on-going nature of chronic pain.

Employees wanted employers to have a positive influence on the GP-patient consultation by offering more active support and engagement which could have enabled discussion of a wide range of return to work options. However employees frequently complained that managers did not communicate with GPs, rendering GPs unable to contribute much to the return to work process. It was shown in section 9.1a above that employers saw matters the other way round, i.e. that they attempted to communicate with doctors, who did not respond. This apparent contradiction is possibly due to the study sampling strategy, as participants who volunteered were likely to be interested in pain, work and sick leave: indeed, most reported proactive strategies to facilitate appropriate periods of absence and return to work. Perhaps less important than who is to blame is the problem that communication and collaboration rarely occurred. Also, this contradiction over who fails to communicate with whom could be due to the partial nature of one’s own viewpoint; exploring the employer-employee dyads was useful in this regard.

As reported in the methods for this study (chapter eight) three sets of dyads were recruited, in which either an employee asked their manager to participate or the manager was recruited first and then asked their employee to take part. Two dyads had positive narratives about each other, and also similar and complimentary reports of particular GPs, who did communicate in detail with companies, although only when asked. The third dyad reported negative things about each other as boss and worker, and had different views of GP-workplace communication. The manager reported that her overall experience of GPs was that they failed to communicate in enough detail with the company, simply signing people off, whom she thought could certainly come back on phased returns, for their own and the company’s benefit. This manager also discussed the particular case of her paired
employee, saying: “I mean we have had her GP talk to our doctors” [Employer 9], showing the communication was initiated by the company. The manager explained that one aspect of the GP’s information was helpful (the likely effect of pain medication on the employee’s work). However, the manager found the in-house OH doctors far more useful, as they knew the workplace very well. In contrast, the employee repeatedly stated that her GP was “very supportive” whereas she had become disillusioned with her manager’s response to her ill health. She reported that the GP had not filled out the fit note in a detailed manner and “Even if he did, I’m not sure if it would be taken on board here [at work]”. Hence the same issue (lack of detail on the fit note) was seen by the employer as a signal that GPs were not fully engaged with return to work, and by the employee as inconsequential, as the fit note would not be utilised properly by managers.

9.3b Summary

Employees thought that employers and workplace procedures influenced the GP-patient consultation. Occasions where employers directly tried to influence sick-listing by speaking to the GP were rare. Indirect influence, where the employee paints a negative picture of the workplace and the GP responds by issuing a sick note, appeared more significant. Employees did not think bosses believed in their ill health until symptoms were visible, and lack of communication from employer to GP, rendered employees wary of returning, which they told doctors, and doctors largely responded by keeping them signed off. Employees wanted more support from employers, and hoped this would influence how they and their GP made capability decisions. However, comparing the views of an employee-employer pairing showed each had different perceptions of the dynamics. The employee wanted more positive input from their boss and was pleased with their doctor whereas the employer reported it was difficult to obtain useful information from the GP. Additionally, poor communication between employers and doctors was blamed on employers whereas it was shown above that employers blamed doctors. This contradiction may be due to the sampling strategy or because the same finding can be invested with different meanings by different stakeholders. The current system of how workplaces manage return to work does not appear to fit the problems experienced by chronic pain sufferers.

9.4 A diminished sense of self

9.4a Employers: conflict over sick leave and return to work inhibits being an ideal boss

Many employers found that managing sick leave challenged their ideas of what it was to be a good boss as they worried about how others viewed them:

“There’s a whole fear around being seen as discriminatory or bullying…it’s very hard to know, there’s a really fine line between how much contact you [should] have to be supportive and when it’s seen as being intrusive”[Employer 4]

Thus, managing sick leave and return to work could cause conflict in the manager’s work habitus and challenged their identity as an ‘ideal’ boss.

Another employer articulated her concern over how both she and her employee would be viewed because of how the business required her to behave:

“I just think you need to stick to the rules but you also need to have some compassion. It’s not just getting the business done, people have got feelings I think. And at the end of the day I think it also reflects on the manager and the person. She felt she was going to come back and no-one was going to talk to her because her work had been given to other people…and I didn’t want her extra work to be given to other people but we have to do it because that’s what the business wants us to do”[Employer 7]
The above situation was part of a paired employer and employee situation in which the protagonists warmly praised each other. Even so, this manager found herself torn between wanting to help her employee as much as possible and having to follow organisational processes.

Employers specifically discussed how their difficulties with managing sick leave were exacerbated if it was given for chronic pain:

“These fluctuating conditions like fibromyalgia are really hard – it’s not that I don’t believe them or don’t have compassion for them, but they’re a managerial nightmare. Even managing an employee who had cancer and died was easier in some ways than this…we knew where we were. With this we never know”[Employee 12]

Employers also reported they felt they had done everything they could without achieving a positive outcome:

“We’ve done all that for her, and spent thousands of pounds on a different workstation, a different chair, she had different software put in so she didn’t have to type…so we put all that into place and you know it’s been a bit better…so I’ve basically invested a lot of time with her on a monthly basis and I said ‘this is what I need you to do and this is how we are going to measure that we have done it’. Is she a valuable member of the team? Yes. Is she as productive? No. She can’t do a lot of things that other people do who are paid the same, so from a business perspective it’s very hard to deal with…sometimes I’m almost at my wit’s end to think what else I can do”[Employer 9]

Most employers found it difficult to balance the needs of the worker with those of the business, and were torn between having to minimise the impact on the business whilst also being humane. Employer 9 found this especially difficult and many of her comments focused on it:

“Because she gets tired and suffers pain, we made adjustments to her workload, so she’s working at home 2 days a week which is a problem because it means we have to deal with reactive things in the office, we don’t have office cover. You know it’s trying to give her every opportunity but I guess what I’m trying to say is she doesn’t help herself. You know like anything in life you have to, you know, there are things that you can do to help yourself and you have to take responsibility really. I think it’s not helped by the fact that she does live on her own so she probably doesn’t have other people to talk it over with. But I also have to work upon the impact that it has on the team…and there is a perception as well that they have to pick up more work because she’s not doing it and yet she is paid the same as they are…you know when she says ‘I’m in pain today’ and I’m saying ‘well, I’m really sorry but, I mean I pay you to work, I’ve done all these things that I can to try and support you’. I don’t feel personally, and I’m not saying anything I haven’t said to her, that she gets enough out of her life. You know she’s got the horrible thing of having to face pain for the rest of her life in some way. But at the end of the day as well you have to try and get the most out of it. That’s easy for me to say because I don’t have those levels of pain but you know I want to try and help her to get to that point. I think that, you know, it’s getting the balance and at the end of the day, being empathetic, sympathetic and putting into place what you can to support a person to get them into the workplace but at the end of the day you have to be realistic from a business perspective”[Employer 9]

This quotation shows the employer had compassion for the worker, whilst simultaneously worrying her performance was below par and that this was affecting colleagues too. The employer made her managerial role comprehensive, discussing the employee’s life, not just her work, and she appeared to feel conflict between her desire to help the employee
and the business's needs. The employee concerned was also interviewed and resented her boss’s input, as she was sensitised to her manager’s conflicting role pressures. The employee felt that over time, her manager could not cope with the chronicity of her pain. There is a hint of the Parsonian sick role here; the patient’s duty to recover as quickly as possible, but chronicity impedes them, so they become less deserving of others’ help.

In summary, employers found the return to work process for workers with chronic pain hugely challenging. It required them to balance competing narratives of legal and business requirements, what a person in pain might reasonably expect, and what managers might expect of an employee. Additionally, chronicity appeared to invoke problematic notions of deservingness and undeservingness, as employers wanted employees to take more responsibility for feeling better, whilst also showing some recognition this might be very difficult. Chronicity also highlighted the problem that many pain conditions could initially be managed by temporary alterations but empathy and the ability to sustain practical support measures waned over time.

9.4b Employees: sick-listing and return to work challenge one’s sense of self

Employees suffered from a fractured sense of self in their own and others’ eyes:

“I’ve always worked. I do quite enjoy my job…not particularly the constraints that I’ve been put on me lately but I do enjoy the job though. I enjoy, you know, my colleagues and the social side…it’s what I’ve always done. I’ve never sat at home. It’s not me, you know. No, it’s not me at all. No. I find it really difficult now” [Employee 8]

This quotation shows difficulties accepting the restrictions of the sick role for oneself. Many employees were simultaneously very aware of the effect of absence and reduced capability on colleagues, worrying that they were viewed negatively:

“I’ve two nice ones [colleagues] who can see when it’s a bad day and will make me a cuppa…but the rest don’t know why I don’t carry all the files like I used to and one especially grumbles about what she’s doing instead of me doing it” [Employee 2]

Chronic pain’s invisibility led to fears of being stigmatised. Several employees reported using particular approaches in order to be taken seriously which had adverse consequences:

“I’ve even gone in on days I’ve been really bad and I’ve had to be sent home. Just to show them how bad I can be…now I’m in Catch 22 again” [Employee 8]

Many employees reported feeling that they were being treated unfairly by management, once they returned to work:

“When I got back to work I was very, very uptight and when I looked at my timetable it was all bottom sets. ‘Oh you’ve been off’. Because I’ve been off before it doesn’t mean I’ll be off now. I was off because I had a poor hip and it was very painful. Now I’ve had a replacement hip so I can do the things everyone else can do. And I thought, they’re doing it because in a sense that was their excuse” [Employee 1]

Even if the workplace was supportive, being absent affected one’s sense of belonging:

“I came back after I’d say about a year, pretty much a year of continuous absence from work, and some people made absolutely no comment, others were saying, oh where have you been. It was really strange. So, I didn’t need to make very much of it, people who
knew about it were quite interested to hear about it. But I didn’t feel like I belonged there anymore, and that was the difficult thing” [Employee 3]

Hence, sick-listing and return to work reduced employees’ sense of what they could achieve, made them worry about how others perceived them, changed what employers asked them to do, in ways they did not like, and made them feel they did not belong socially.

Just as employers’ data showed they recognised elements of employees’ altered sense of self, so employees also reported awareness of things with which managers were uncomfortable. Employee 6 reported her perception that her manager was in conflict with HR over her:

“I’ve said it to her [the boss], I said, I don’t want to be a burden on you and she says, you’re not a burden, it’s my job as well, I have to look after staff myself…and I know that she’s feels a bit in the middle…and when we were at this meeting…I raised the issue of what this woman from HR had said, and this HR woman put her on the spot. It’s not fair on her...there isn’t anything else she can do”

This employee appreciated her line manager’s efforts and was upset by HR’s perceived bluntness, but elsewhere stated she could understand why her fluctuating condition was hard to manage and even said she would not employ someone suffering from her chronic pain condition if she was recruiting staff. This comment portrayed her diminished view of herself as a worker. This comment also encapsulated the two key themes in this section: the on-going problem of being accepted at work as even if physical pathology was receding, social identity remained spoiled in the eyes of oneself, colleagues and bosses; and simultaneously understanding that employers struggled with managing chronic pain sufferers in the workplace.

9.4c Summary: comparison of protagonists’ views

Managing sick leave tested employers’ professional skills, and led them to struggle with reconciling their compassion for the worker with organisational pressures. Employees found sick leave difficult as it altered their sense of self; some had to show they were in pain in order to be taken seriously, and they felt they were treated differently by management. Even if the workplace was supportive, many felt they simply did not belong any more. Both employers and employees reported awareness that the other party was struggling with an altered sense of self and there was some understanding on both sides for the other. This understanding may in part have been as both sides were undergoing a similar sense of an altered self, i.e. as not such a good worker or boss as one thought one was. This altered sense of self on the part of both employer and employee appeared to be what made managing sick leave especially challenging, over and above the practical problems with implementing phased returns and adapted duties. It suggests rehabilitation needs to include repairing social identity as well as restoring or accommodating physical functioning.

9.5 The policy response to rising sickness certification rates
9.5a The fit note: A step in the right direction or sustaining the unsustainable?

This section considers how the fit note is experienced by employers and employees and whether or not it might help with some of the challenges of sick-listing and return to work explored above.

All managers thought the fit note had potential but that this was often wasted, by being poorly completed and/or poorly used by organisations. Most large companies reported that they already had good procedures in place for the four options encouraged by the fit
note (phased return to work, altered hours, amended duties, workplace adaptations) so it had not changed their management of sick leave:

“I’m managing a lady with CFS and undiagnosed pain. She’s come back on a phased return, and the fit note did say that but to be honest, we would have done it anyway. I remember we did it a few years ago for another lady.” [Employer 5]

Over half of the employers (from all size organisations) reported that they did not use the fit note actively, other than for HR pay procedures. In some cases, this was again because they already had good OH systems in place:

“We don’t actually do anything with the fit note. So I get a fit note back and our employer services department will record the fact that somebody has been off. So in terms of you know SSP [Statutory Sick Pay] and that sort of thing…I’ll put the note in a file but nobody’s going to look at it or do anything with it. So it’s kind of, you know and it’s another bit of paper when you’re trying to work in a paperless environment…The fit note hasn’t made any difference to how we work, but that’s also because we have our own processes” [Employer 9]

However, some line managers in larger companies felt intra-company communication was poor and they would have liked to see the fit note, rather than it ending its journey at HR. They reported awareness of confidentiality issues but felt that accessing the note’s information was crucial to plan appropriate return to work.

All managers liked the positive impetus of the new note, as they felt it could focus back-to-work debates on capacity and importantly that it actually invited discussion about what people might be able to do: “I believe the well note is better because it opens things up” [Employer 2] and “It initiates conversation which is good” [Employer 10]

Employers were concerned about where their own liability lay and felt that GPs were completing fit notes conservatively for the same reason. Some employers said the fit note had no power to change things because of this. Others felt it lacked power as it did not change the fundamental position that the employee was the main driver in the capability decision:

“Well that person can decide to do what they like about it. I can initiate conversation and phone that person and say ‘I notice your note said if we gave you half a day’s work; how would you feel about that?’ If they said ‘I really don’t feel I’m ready for that’ what can I do?”[Employer 2]

Some employers were annoyed that they had felt the fit note was going to improve things but it had not as doctors were still not changing their usage:

“I was really excited about this, because I thought it would give us the flexibility we need…we have been getting the fit note on a regular basis now as an employer and not once has it said the person might be fit to work”[Employer 6]

Many employers reported conflict between fit note recommendations and those recommended by OH, as detailed above. Others reported that even in big companies, they were unable to take on board fit note recommendations due to limits of the job roles:

“If you’ve got a bad back as a baggage loader you have to be able to lift a bag. You can’t really do anything else and generally we don’t redeploy people to other duties because it’s just, you know, if you’re a baggage loader you’re a baggage loader, if you’re a pilot you’re a pilot” [Employer 9]
Even in cases in which there was no conflict between fit note and OH recommendations, there were issues with how the former were implemented in the workplace:

“The difficulty you’ve got as an employer, is getting staff to understand that that has to be a balance. I remember a case that’s actually in the organisation where we’ve put in adjustments which are just not sustainable. And this has had a very severe effect on the organisation. The individual actually hasn’t…it hasn’t enabled that person, to fully do the job…it's kind of sustained the unsustainable. And I think that’s something that needs to be carefully considered” [Employer 11]

However, this employer still said the fit note was “the right change”: this appreciation of the direction of travel of the fit note, combined with real world problems when managing it, was very typical of employers’ responses to it.

Employees reported similarly ambivalent views. Many reported that the fit note had assisted their return to work both psychologically and practically. Many liked its positivity and appreciation of a continuum of fitness which was useful for chronic pain:

“I think psychologically it makes a difference, because you feel like you’re getting somewhere. For a long, long time I had dealings with the old sick note - wasn’t it just you’re sick and can’t go to work or not sick and can go to work? That’s pretty categorical. And it doesn’t appreciate the grey areas. I don’t think it’s as simple as you’re sick and you can’t go in, or you’re fit and you can go in. And I think for me, it was nice to see on the back of that note, you’re fit for work…because it felt like a little bit of a victory. Because I’d been unfit for such a long time and that kind of spurred me on, in a way, to get back to work, so I think it terms of the language on the note, it’s definitely beneficial” [Employee 9]

And many employees appreciated that the fit note promotes more options than the sick note:

“My GP ticked phased return…it was a condition of going back that I had amended duties…the fit note helped, because on the other one, the old one, you didn’t have any of these options”[Employee 8].

Conversely, some employees felt that the conditional wording on the fit note regarding workplace adaptations, phased returns etc. was being used to bar their re-entry to work:

“‘If available and with the employer's agreement, you may benefit from…’ Yeah. That’s their get out”[Employee 6].

Just as some employers felt powerless against aspects of sick-listing and that the fit note had not changed that, so employees reported similar powerlessness, only this time against the employer:

“My GP has written them two actual letters, in addition to comments on both the old [sick] note and the new one, and they’ve not responded. She wrote on the fit note that I need help carrying clinical notes which are very heavy. My line manager’s seen this request and said before Christmas that we must do something about this but nothing’s been done” [Employee 2].

This employee reported she felt unable to raise this issue again for fear of being seen as a trouble-maker, especially as her organisation was about to undergo restructuring and she was worried about redundancy.
9.5b Summary

Employees reported the fit note might help specifically with chronic pain as it allows for grey areas: they liked its appreciation that fitness for work is not necessarily black and white. Employers thought the fit note has the potential to re-frame back-to-work debates positively. Yet both employees and employers reported gaps between agreeing with the positive principles behind the fit note and being able to implement it. Implementation problems were discussed in practical terms, such as how workplaces might not be able to accommodate recommendations but also in the light of power relations, as each group emphasised that the fit note did not change elements of sick-listing and return to work over which they felt powerless. For employers, this was that employees have the final say over capability decisions, and also that they are powerless against employment law, although as none of the employers were clear about the fit note’s legal position, their powerlessness may reduce if they gained such clarity. The note’s legal standing is returned to in the discussion chapter to consider the constraints on managers, HR and OH staff and how far their defensive actions are justified and how far they may be due to lack of confidence in the light of a new initiative and from previous experience of tribunals about sick leave and ill health retirement. Employees did not think the fit note changed the powerlessness they experienced with sick notes over whether or not GP information was utilised or even just carefully considered by managers.

Conclusion

A major problem appeared to be who was perceived to have the power in both the capability decision and the workplace's management of sick leave. Employers stated employees and doctors were often in control, whereas employees reported influence from the workplace affected how they enacted the role of patient in GP consultations. Ideally, the GP-patient interaction would produce detailed information of use to the managers who would actively solicit and consider it, in communication with the employee. This is what most protagonists reported that they wanted but the findings of this study show such communication rarely occurred. The system did not promote the three-way discussion needed, and heightened people’s sense of where they departed from ideal roles rather than what could be collaboratively gained. The employers’ interviews show tension between narratives of sympathy for the employee versus worries the workers lacked resilience and that doctors colluded in this, usurping employers’ power. This made employers feel disabled from positive action and also tense that another narrative concerns their need to run a business whereas they implied employment law and the welfare system are too weighted towards the employee. Chronic pain exacerbated these issues due to its very chronicity as well as difficulties managing fluctuations, both in a practical sense and also as employers wanted consistent, tangible signs and symptoms of illness, which could be absent. Employees with chronic pain were often unable to enact the classical sick role duty of recovery, leading to employers struggling with maintaining sympathy. Employers often used OH information in preference to GPs’ but reported this was partly as the latter was of poor quality. Employers stated that they actually wanted more information from GPs, as they valued doctors' holistic knowledge of employees (although not doctors' workplace knowledge).

Employees reported that whilst they and their doctors made the capability decision in general practice, away from the workplace, this decision was indirectly influenced by the workplace i.e. its social norms, working conditions and employees’ relationships with managers. Employees reported they and their doctors have little power over how return to work processes occur as fit note information is not properly used by employers. This issue was influenced by the on-going problem of stigma being maintained even if physical pathology was receding. Employers engaged in phantom acceptance of employees, treating their social identity as spoiled even once they returned to work. This also relates to data showing that types of knowledge (medical versus occupational) were situated by protagonists as largely at odds with each other and different accounts privileged in
different cases rather than being used in collaboration; knowledge was power in a very Foucauldian sense. Also, power relations between these two arenas were dialectical: one could influence the other which in turn shaped how interactions then occurred in the first. The clearest example of this was an employee being pressurised by her manager to provide a diagnosis, who then entered into conflict with her doctors to get one, which then influenced how the manager responded to her sick leave.

Drawing all these strands together, protagonists’ experiences were that the current system does not fit many problems surrounding return to work for chronic pain sufferers and their employers. Although each party often blamed the other, the more important finding was that collaborative communication rarely occurred and that stakeholders felt they were forced to depart from the habitus of being a good boss or employee. The discussion chapter will now consider these results in conjunction with those from study one, using relevant theory to draw together insights and suggestions for the future.
Chapter Ten: Discussion

Introduction: Aim and research questions revisited

The aim was to describe and elucidate the social construction of chronic pain as a reason for work absence in the UK, focusing on the negotiation of sickness certification and return to work, and how these micro-interactions relate to factors at the macro level, such as, social norms, medical discourse, and the formation of policy initiatives. This aim was tackled by reviewing a broad and diverse literature including: research on the nature of chronic pain; the relationship between work and health; the sickness certification process; the doctor-patient relationship and analyses of recent policy developments, as well as drawing on relevant concepts and theories from medical sociology. Two qualitative empirical studies were conducted adopting the standpoint of symbolic interactionism and a constructivist GTMs approach.

In this chapter the empirical findings are synthesised with insights from the literature review to develop a grounded theory which elucidates the processes by which sickness certification and return to work for chronic pain patients are constructed.

The research questions were very open ended, by virtue of the interpretivist standpoint from which they were developed. A particular set of answers to the research questions is offered, but it is important to clarify what is being claimed for these findings. The ontological and epistemological assumptions of my methodological standpoint suggest that the study of social phenomena cannot access an objective reality in an unmediated and incontestable form, but must rather comprise the construction of an explanatory narrative that is influenced by the context in which the research is conducted and the methods that are adopted. Other methods and other researchers may have produced other answers to the same research questions. However, without wishing to question the plurality of potential readings, I have attempted to demonstrate the plausibility of my findings by embedding them in a thick description of context, and attempting to be reflexive about my viewpoint and methods, so that readers can assess the veracity and transferability of my conclusions (Patton, 2002; Charmaz, 2006).

10.1 A grounded theory of sickness certification for chronic pain

Social norms and values about what it is to be a doctor, what it is to be a well person who works, an unwell person who does not, and an employer who employs an ill person, are very potent in the negotiation of sick and work roles, and the kinds of relationships between patients, GPs and employers that underpin them. Sickness certification for chronic pain depends on the negotiation process within the consultation itself, deriving from what the doctors and patients bring with them to the consultation. Patients’ descriptions of their jobs, and employers’ responses to sick-listing, affect sickness certification negotiations, which are also problematic within the workplace.

10.1a Elements the doctor brings to the consultation

The doctor brings professional values of wanting to care for the patient and do the best for them, and central to their habitus is keeping the doctor-patient relationship intact for however long the patient comes to see the doctor. In a minority of cases, doctor and patient agree on the capability decision, but mostly, the doctor must balance preserving the doctor-patient relationship with persuading the patient to go back to work if that is what the doctor thinks is best for the patient but the patient does not, or persuading the patient to stay off sick if that is what the doctor thinks best. Doctors want to be ‘good’ doctors, and are keen to avoid direct confrontation with patients, seeing this as a contradiction of their role. This can be characterised as role conflict. On one hand doctors want to apply their expertise to do what is best for the patient, but at the same time, they are trained to be ‘patient-led’ seeing themselves as an advocate for the patient or a partner in the treatment process. In the case of sickness certification, they will not send the patient back to work if
they think that a particular job is in some way bad for the patient’s health, even if they believe that work per se is good for most people. The doctor has extensive medical knowledge to bring to the consultation but is also aware that many sickness certification decisions, for people with chronic pain, are not based in medical science but involve socio-political decisions. Doctors are aware that they are the gatekeeper to the benefits system, although they will privilege the doctor-patient relationship above this. The doctor’s personal views on the benefit system and the wider economic climate affect sickness certification: if they think a patient is becoming too dependent on benefits to their own detriment, they are likely to try harder to persuade the patient to go back to work. However, if they think that the benefit system can be punitive to patients, then they are more likely to offer support to them in the form of state-sanctioned legitimation to be off, i.e. they will sign patients as not fit to work, to give medical support to patients’ claims for sick pay.

The doctor has their own mode of practice. The doctor decides whether or not to give a note even if they think it unwarranted. They also decide to what degree they will negotiate with or challenge patients’ views if doctor and patient are not in agreement. Most doctors have the mode of practice that they will ultimately give patients what they want, although there are varying degrees to which they will challenge them. Some doctors are very gentle and others are much more assertive, overtly asking for things in return for providing a sick note, such as patients’ active engagement in target setting. Only a tiny minority of doctors include within their mode of practice refusing a sick note if the patient asks for one; most will not do this as they privilege the doctor-patient relationship, wanting to keep it intact for other occasions, related or unrelated to sick leave, upon which they want the patient to be able to feel they can ask for the doctor’s help. The degree to which doctors invest time challenging patients’ ideas is also affected by wider structural constraints such as whether or not they are running late with consultations that day, and whether or not they feel the patient can access good vocational and physical rehabilitation services.

10.1b Elements the patient brings to the consultation
The patient attends the consultation with a wide range of attributes which affect how the negotiation process will unfold. The patient brings with them their own ideas about their workplace and whether or not it has exacerbated or even caused their ill health. The patient will describe their ideas to the doctor in a way that fits the patient’s aspirations about the outcome of the consultation. This aspiration may or may not be in accordance with the doctor’s views. The patient will bring to the consultation ideas of to what they are entitled. This sense of entitlement is focused on, but not limited to, the negotiation of whether or not a sick note is given. Entitlement may concern being accorded state-sanctioned legitimated time off, with sick pay or sick benefits. However, it may also concern accessing help to remain at work, even if the doctor does not advise this. The things to which the patient feels entitled are not only to do with the actual issuing or withholding of the sick note per se but include entitlement to other processes which affect the decision of whether to be signed off. These include a desire for the doctor to attend fully to all elements of the patient’s communication, regarding the nature and import of their pain, and their opinion of the relationship between any elements of their life they choose to discuss and their pain condition. Many patients discuss not only their job and workplace culture, but their levels of social support, financial situation, and how these impact on their ability to work. Patients are very clear that their lay knowledge of their own body, their pain condition and how they may or may not be able to work, are not only as important as the doctor’s medical knowledge but can often surpass it. In this way, just as for the doctor, sickness certification is often not so much a medical decision as a social one. Just as GPs have a mode of practice of being a doctor, so patients have a mode of being, which includes how they conduct themselves within the consultation and how they see themselves outside it. Some patients discuss their resilience, using this to persuade
the doctor that they should concur with the patient’s view that staying at work is the best decision. Other patients use example of resilience up to this point to show how they now want a break from work in order to repair themselves, or want to continue being off in order to consolidate reparation. Still others may choose to emphasise the difficulties they face, at work and at home, to negotiate (further) time out of the labour market.

10.1c Processes within the consultation
The onus is officially on the doctor to elicit information but doctors are aware that communication of the effect of the pain condition depends a lot on how well or badly patients can report signs and symptoms of their pain condition and express how this affects their capacity to work. Patients also enact their condition by pain behaviours such as guarding, limping, facial and bodily expressions. They may do this consciously or unconsciously. The doctor must assess this presentation by observing and examining their pain behaviours, carrying out appropriate tests (often limited in primary care to visual analogues, numerical scales or the McGill Pain Questionnaire), and then provide diagnoses and prognoses if possible and appropriate.

The patient must articulate their view of their job and workplace culture. The doctor must try to understand as much as they can about what the patient is saying. The doctor may find many of these articulations frustrating as often they do not know much about the patient’s specific job and workplace and it is difficult for them to determine the degree to which they think a particular job and particular working environment may help or hinder the patient’s health. Nonetheless, the doctor must appraise capacity for work. The patient often feels uncomfortable by having to enact pain that they may not be feeling at the precise moment of the consultation: even if they are merely communicating how badly they suffer when fluctuations leave functioning at its worst, patients feel as if they are somehow acting, hence might be disbelieved. The indeterminacy of many chronic pain conditions, and the lack of doctors’ knowledge of many workplaces, often result in contestation between the doctor and patient. This is usually overtly arranged around the patient wanting to be signed off and the doctor not thinking this is in the patient’s best interest but eventually sanctioning it anyway. However, it can also be focused on the patient’s determination to stay at work when the doctor prefers a period of recuperation. Furthermore, even if doctor and patient agree on the capability decision, there is often contestation regarding the amount of time one should be off work (or should remain at work before the situation is reviewed), and how a return to work can best be organised. Additionally, patients often want a medical diagnosis to be named as part of their sickness certification process, whereas doctors are less concerned with such labelling. These areas of contestation relate to the struggles of meaning engendered by the sickness certification consultation: it is very rare that the consultation will run smoothly with both parties feeling entirely satisfied and legitimated.

10.1d The struggle for meaning
It is difficult for the doctor to manage the inconclusive nature of knowledge about many chronic pain conditions which may have no clear diagnosis, thwart notions of a cure, and fluctuate, making treatment and capability decisions hard. These challenges to the doctor’s traditional biomedical knowledge can be helped to a degree by invoking the biopsychosocial model as the doctor can discuss and negotiate with the patient regarding: how graded physical activity both at work and home might help (e.g. keeping a sore back moving, if red flags have been ruled out); how their mood might be improved by a gradual return to work, or by rest from it; and how their social support network might be useful. However, the patient often wants a conclusive diagnosis, or at least a treatment package, arising from the biomedical knowledge which they expect the doctor to display. This is part of the patient’s struggle to be recognised as legitimately unwell, both by their employer if they have one and also by others in their social sphere, notably their family and friends. Furthermore, they do not want to feel castigated by broader socio-political rhetoric which
seems to them to focus on weeding out malingerers. On the one hand patients try to ensure doctors listen to their psychosocial issues with sickness certification for chronic pain, such as difficult relationships with bosses and problems moving between the identity of a well person at work and a sick person at home. On the other hand, patients often find psychosocial explanations for their chronic pain condition stigmatising as they feel it invalidates their position as unwell person deserving of societal benefits (whether fiscal or Parsonian removal of blame). Patients want the biomedical certainty in addition to the psychosocial understanding i.e. patients want the biopsychosocial model fully implemented. This is difficult for doctors as its elements do not always naturally coalesce. Doctors’ traditional authority is also challenged by their lack of workplace knowledge. Patients know they have an edge over doctors in this regard. They also know doctors are likely to give them a sick note. Patients use this knowledge to persuade doctors to give them a sick note as smoothly as possible. Patients know they may have to enact pain they may not be feeling exactly at that moment, which can be stigmatising. However, patients are pragmatic that this is something they are willing and able to do in order to get the doctor to agree with their wishes. Doctors invoke a similar pragmatism, using their biomedical knowledge, biopsychosocial knowledge, any relevant knowledge of a particular job or workplace, and of an individual patient with whom they may have a longstanding relationship, to decide how much or little to try to persuade the patient to their way of thinking. Sickness certification disrupts the ideal patient and doctor roles, hence the social order of the clinic, as patients have to enact, articulate and supplicate, whilst GPs must balance compassion with their gatekeeping role; both parties enter into conflict with the other.

10.1e Residual dissatisfaction for the doctor and patient

Whether or not the sick note is issued, both parties are highly likely to suffer from residual dissatisfaction with the consultation. This may result from either party not agreeing with the capability decision, even if they do not articulate this dissent in the consultation. However, even when both parties acquiesce with the decision, they often suffer dissatisfaction with the negotiation processes within the consultation. The doctor feels their knowledge, status and habitus have been challenged by the double complication of the indeterminacy of chronic pain and the lack of knowledge about particular workplaces. Many doctors experience an uneasy alliance between the biomedical and newer psychosocial approaches, as a tension in the habitus of general practice. Biological reductionism does not usually entail value judgements or issues of morality, at least not directly, yet this approach has limitations when it comes to managing illnesses that have a strong psychosocial component. Addressing psychosocial issues tends to draw doctors into making more subjective appraisals, and value judgements with which they often feel uncomfortable. Doctors want to be effective, and to be good doctors, and when the biomedical model cannot provide clear answers to chronic pain, they at least want to respond humanely and warmly to suffering, partly as that is a component of the medical habitus (e.g. Parsons’ ideal of the caring sympathetic doctor (Parsons, 1951) and simply their bedside manner) and partly to compensate for the shortcomings of biomedicine. Giving a sick note is one way to do this for many doctors.

The patient feels partially invalidated if the doctor has queried their account of their pain or workplace in a manner that feels more than simply trying to reach assessment but rather in some way testing the patient’s agenda or veracity. GPs use their cultural capital to support their professional role, but sickness certification for chronic pain diminishes doctors’ cultural capital as their knowledge is under scrutiny. Certification also interferes with patients’ habitus as credible sufferers and stoical beings.

10.1f The employer dimension

Employers have to balance the competing narratives of the therapeutic/medical habitus (with its emphasis on improving the health and well-being of the patient) and the
business habitus (of organisational efficiency, work performance, reciprocity in terms of people being paid to do a certain job and ultimately the 'bottom line'). The two domains intersect in the desire to see highly valued employees return to optimum performance, but conflict arises when recovery is incomplete, intermittent and where the value of the employee is not considered to warrant the costs of adaptation/disruption.

How managers respond to sick leave is affected by a complex web of factors. A central component of this is their view of the individual employee. If an employee is highly valued by the employer and performed their role well before they became ill, employers are more likely to want to help them to return to work. Thus, employees have a perceived ‘market value’ and ‘track-record capital’. However, this ‘capital’ wanes relatively fast, if the return to work process is protracted, disruptive or costly. Employers consider the moral identity of their employees: how far they appear able and willing to take responsibility to get better is judged, and over time, employers often feel less sympathy for those unable to follow the normative expectations of the sick role and return to full health and performance. Employee and employer thus have strong, antagonistic relationships.

Managers’ responses to sick leave are also influenced by pressure from their own bosses and the overall needs of the business: not only its bottom line but also how it may or may not be able to incorporate people who are not 100% fit without damaging its structure, for example by the negative effects of covering for the absentee on colleagues, or by any slack in the system being used up by an under-performing worker. Employers evaluate the effort-reward situation. They are likely to feel this is unbalanced, as their efforts to reintegrate workers using extensive workplace adaptations and phased returns are not justified by their perceptions of employees’ subsequent performance. It is unlikely that employers will feel that their efforts to retain staff pay off, in terms of employee performance. Employees struggle to manage working with their pain condition, and are likely to become aware that despite their efforts, their performance is not up to expectations, so feel unfairly castigated. Managers will access OH resources if possible, although lack of timely appointments will make return to work even more problematic for both managers and employees.

Negotiations around the duration of sick leave and planned return to work are likely to be very vexed. In many ways, this vexation mirrors that of the doctor-patient axis discussed above. The employer and employee struggle with the subjective nature of chronic pain in similar ways to those played out in the general practice consultation. For example, employees often feel they must enact pain even if they are not feeling it at that precise moment, in order to convince employers that a fluctuating, perhaps not highly visible condition is real. Employees may use physical aids such as walking sticks to help persuade employers of the seriousness of their condition. Employers usually find this helpful, as it gives some tangibility to uncertain conditions. Furthermore, Parsons’ ideal patients are meant to work towards recovery and employees/patients feel censured if they do not or cannot; this norm is no less potent in the workplace than in the doctor’s surgery, as it feeds into values around having a strong work ethic, and showing resilience in the face of adversity. Employers construct employees who have chronic, fluctuating painful conditions in different ways, but a common construction starts off positively, as the employee is seen to be trying to get better and get back to work, and disintegrates, as the employee is unable to sustain working in their previous manner. Employers find this disintegration challenging, as it leads them to think of themselves differently, as someone who is not as humane as they would like to be, as they have to respond to competing pressures to help the employee and balance the business needs. Thus their self-image is changed by sickness certification and return to work issues, mirroring the role conflict experienced by doctors over sick-listing.
Employers find it hard to trust all their employees’ accounts, in the absence of pathology which appears to account fully for someone’s pain. Just as many doctors concede to wishes for sick-listing, so many employers have nothing they can really do to get someone back to work whom they feel is able to be productive. However, whereas doctors often sick-list to preserve relationships, employers are less concerned about this, and more concerned about keeping all elements of a business up and running, as well as discussing how they genuinely think it would be better for some employees’ health outcomes to be at work rather than at home.

Some employers feel that their workplace’s culture encourages low resilience and that their authority over an employee is diminished by the GP who can sick-list with impunity even when the employer thinks this inappropriate. Employers will acknowledge GPs’ medical expertise, but are aware that doctors do not tend to know specific details of a workplace. Employers feel very frustrated by their perception that this kind of knowledge is diminished in the general practice consultation. Some employers suspect doctors conspire with patients in sanctioning malingering, or that patients manipulate doctors into this. This directly affects how they see their relationship with the employee and their doctor. Chronic pain exacerbates employers’ doubts and frustrations about their perception that they lack power to influence return to work processes, as they do not have tangible symptoms to inform their judgements in many cases. Employees find that the subjective elements of chronic pain negatively influence employers’ views on their sick leave and their return to work. When chronic pain sufferers came back to the workplace, they find that their identity as worker is spoiled, as others view them as a social curiosity, a figure of pity or visit anger on them for being unable to work how they used to. Even if a person appears in robust health, or physical pathology has been repaired or removed, social identity still needs to be repaired. This is very important, as without such repair, stigma remains, and affects how both employee and employer conduct themselves. This also shows a way in which employers have power over employees that is very difficult for the latter to manage. Employees perceive that they are fulfilling their side of the bargain and are back in their job role, either doing what they see as the same quality work as before or at least their best, and yet they are unable to fit back in socially, and begin to feel anxious, angry and disengaged from the workplace. In extreme cases, employees may actually leave their jobs as a result, or be got rid of in some way by employers (retired on ill health grounds, made redundant or dismissed, all of which can be legal responses if done with care) and so protracted return to work negotiations can come to naught.

Just as doctors and employers each find that the other party exercises power over them, in ignoring medical or workplace expertise, so employees and employers each find that the other’s actions hinder the patient/employee’s return to work. Employers suspect some employees lacked resilience, and that society sanctions this through the discourse of entitlement, the weakening of work ethics and to some extent through the medicalisation of everyday life (see Furedi, 2008). Employers feel that they are doubly disadvantaged by being powerless against the medial lore of the doctor as well as these social norms. Employers may experience that some employees are well motivated but became simply unable to do their job, and that the balance in current employment law is weighted too heavily towards the employee and away from the business. However, employees see matters differently and feel judged by the social norm that work is good for us, especially in a recession, and that this rule is not relaxed by employers or society if one is chronically and often invisibly (as opposed to acutely and obviously), unwell. Employees can usually get sick-listed if they want, but recognise that this behaviour is viewed negatively by the employer, who shares the assumption of the current discourse of health, that individuals are responsible for maintaining their own health and are stigmatised if they fail to do so (Bowler, 2008; Wainwright, 2008).
Multiple factors have to be balanced in the management of each individual case of return to work. As there are so many different influences to consider, it can be seen how sick-listing and return to work processes are very delicately balanced. The key word linking all the interactions between managers, employees and doctors is power. As with the doctor-patient axis, the employer-employee dimension is run through with power struggles and conflict, subjective appraisals and moral judgements, with which protagonists struggle. The current systems of sick-listing and back to work processes are constrained by practical elements. They are also governed by overarching social norms around when someone should or should not be at work, what it is to be a good employee and a good boss, and my grounded theory reveals a complex process of contestation and negotiation in which legitimacy and moral sanctions are constructed and challenged.

10.2 Analytic propositions characterising the social relations and mechanisms underpinning the grounded theory

1. The doctor-patient relationship is a power relationship
The state confers the role of gatekeeper to sickness certification, sick pay or benefits on the doctor based on the modernist notion that many health problems are reducible to observable physical pathology. The doctor’s habitus is to do what is best for the patient, which may be in conflict with the gatekeeping role, but still gives the doctor’s professional opinion power over the patient. The patient will probably get a sick note if that is what they want but the doctor does not think it in their best interests, which is the focus for many sick-listing consultations. Similarly, the patient will probably persuade the doctor to sanction their remaining in work if that is what they want but the doctor thinks it unwise. However, the privileging of biomedical knowledge and doctoring as a set of practices means that patients still need the doctor’s actions to accord with their own aspirations. Patients will behave in such a way to achieve this, even if that means enacting pain they do not feel at the moment of consulting, and articulating its effects more strongly than they feel comfortable with.

2. Sickness certification for chronic pain is a socially negotiated process characterised by competing definitions of the situation
These definitions arise from doctor, patient, employer and contested knowledge claims from bio-medical, psychological, moral, social, and economic perspectives. Sickness certification for chronic pain is problematic for the patient, doctor, employer and tax-payer. The indeterminacy of chronic pain brings to the fore limits of different modes of knowledge, issues of trust and dependability. Doctors must manage the challenges to their status brought about by assessing capability for medically unexplained symptoms in conjunction with lack of occupational knowledge. Doctors must also manage tensions between being the patient’s advocate and their gatekeeping roles. Patients fight for diagnoses to lend moral weight to their suffering, and also for the state-sanctioned legitimation conferred by a sick note. Employers struggle to balance competing demands from their own bosses, their organisation’s structure (which often cannot sustain part-time returns, or adapted job roles) and their desire to be kindly towards someone who they may accept is genuinely suffering. Even employers who begin with a high opinion of an employee find this hard to sustain over time, as employees generally struggle with returning to the same type or level of performance they accomplished before sick leave.

3. Current policy largely assumes that sickness certification and return to work problems arise largely from knowledge deficit but this is an ontological and epistemological fallacy.
Policy assumes that if stakeholders are more aware of relevant evidence (that safe and accommodating work is good for most of us, that patients can successfully return to work at less than one hundred per cent fitness) then sick-listing will reduce. Yet sickness certification for chronic pain is very often not amenable to evidence-based medicine, as
the nature of the problem is socially constructed, as suggested in (1) and (2) above. Implementation of evidence-based guidelines is not a neutral activity but rather is mediated by the role of meaning in social situations, concerning how knowledge and power are constructed in micro-interactions.

4. The doctor-patient is a power relationship but not as mechanistic as the formal model (see 1) suggests. The doctor and patient are both ambivalent about bio-medicine. Both want it to work but both realise it often cannot. Both feel uneasy about embracing psychosocial narratives, although the patient more so than the doctor. Neither has the trump card or decisive argument, although the patient’s self-report of symptoms and knowledge of the workplace or local labour market comes close. Doctor and patient negotiate a settlement with which neither is entirely happy. If the patient requests a sick note, this is almost certain to be granted, but it is a pyrrhic victory in most cases, as many patients feel delegitimized by supplication. The doctor is uneasy if they consider a sick note is not in the patient’s overall best interests, often fearing that once the patient is signed off, it will become harder to negotiate their return to work.

5. The employer dimension affects the processes of negotiation within the general practice consultation and vice versa. How patients characterise their workplace affects sickness certification. If patients describe a manager unable or unwilling to respond to the psychological support or physical workplace adaptations that either the patient, doctor, or both, think is needed, then the doctor is highly likely to respond to medical and social norms of doing no harm and sympathy towards suffering and sign the patient off. Employers feel doctors collude in sanctioning low resilience by signing people off too easily and that employers’ occupational expertise is diminished relative to society’s privileging of medical knowledge and also relative to patients’ personal accounts of what their body can and cannot do.

6. Habitus is the repository of the negotiated synthesis and the mechanism by which it is reproduced. Doctor and patient both bring knowledge, experiences, values and expectations to the consultation, some of which are shared, but are sufficiently different to identify a separate habitus for doctor and patient. Habitus includes the congealed accretions of many doctor/patient interactions. This comprises personal interactions between a particular doctor and patient, and also interactions between many sets of doctors and patients, i.e. stakeholders’ habitus embraces a shared set of beliefs and knowledge about what is thought to constitute a good consultation, what it is to be an ideal doctor and an ideal patient. Habitus includes evidence-based practice but also included ‘practice-based evidence’ i.e. doctors’ experiential and tacit knowledge gained over time about how to manage patients, and patients’ similar kinds of knowledge about how to manage consultations to achieve one’s aspirations, and the putting into practice of this knowledge in a new consultation. In the same way, employees and employers bring knowledge, aspirations and values to their interactions, including accumulated understanding about what it is to be an ideal employer and an ideal employee. Habitus structures the interaction but is also structured by it i.e. there is a dynamic process of social reproduction occurring.

7. Habitus is part of the solution as well as part of the problem. Rather than trying to replace habitus with evidence-based medicine, policy should aim to modify habitus to generate some satisfactory solutions. It could:
   - Accept that no amount of evidence-based medicine can resolve the assessment of contestable claims and the need to make value judgements which attends sickness certification for chronic pain
• Recognise with greater openness the standpoints of different stakeholders, embracing uncertainty and plural narratives. This challenge may be eased through a more conscious attempt to use the biopsychosocial model, and to consider which of its elements stakeholders prefer and why
• Strive to satisfice all stakeholders i.e. if it is not possible to achieve full satisfaction of everyone’s needs, then decide on and pursue a course of action that meets a threshold of acceptability

8. The role of policy-making.
Policy needs to provide a macro context in which more fruitful micro-negotiations within the consultation and at work can take place. It needs to consider how to create better external services for chronic pain patients, and a more fulfilling labour market, to empower doctors to negotiate with patients to go back to work. We need public debate on what stakeholders can and should be prepared to do if one hundred per cent recovery is unachievable. We need more explicit consideration of where responsibility lies for enabling people with fluctuating and chronic conditions to work. We need to formulate a new concordat on how the costs of chronic pain should be allocated to patient, employer and tax-payer. If the financial and also social costs of chronic pain were equitably distributed, then it is likely that more effective micro-negotiations between doctors, patients and employers, would occur.

10.3 Synthesis of findings from empirical studies one and two: what this thesis adds to our knowledge of sickness certification for chronic pain

10.3a Relationships between stakeholders
The first key point, synthesised from the literature review and empirical findings, is a description of relations between the main stakeholders, which highlights lines of influence between them. The key relationships are represented in figure 10.1 below. Complete lines represent strong relationships and dotted lines represent weaker ones. Arrows show the main direction of influence or effect.
Thus we can see that there is a strong, reciprocal relationship between doctors and patients, as doctors want to care for patients and patients seek medical advice. Doctors have bodies of medical knowledge to impart to patients and whether or not to be sick-listed tends to be finally decided by the patient, although patients do sometimes respond to doctors’ efforts to suggest otherwise. This point is well established in the literature (e.g. Verbeek et al., 2004; Mowlam et al., 2005; Werner et al. 2012). Although UK government policy implies that patients have a lot of power in the sick-listing decision (by indicating we should persuade more people to work, but ultimately cannot force them, Black and Frost, 2011) findings from my interviews with patients reported their relations with the Government were constrained by their perception that government policies were designed to weed out malingering. There is no line in the diagram directly from the Government to patients, as this relationship is conducted through patients’ interactions with their GPs and employers. Doctors are constrained by the Government which wants them to sick-list less, tightening their gatekeeping role, but the Government also relies on medical evidence and advice to formulate policy, so there are strong, albeit sometimes antagonistic, relations here.

Employees and employers experience pressure from each other. The diagram shows that employers’ influence on patients/employees is weaker than vice versa. Although employers have a lot of power over patients/employees in terms of how return to work processes are managed (explored in section 10.1d, and also by Wrapson and Mewse 2011b) at the point of the sickness certification consultation, it is the patient/employee who makes the decision whether or not to stay at work, not the employer. Employers have influence over the capability decision indirectly in terms of how the patient perceives the levels of practical and emotional support likely to be offered by managers and workplace procedures, but are at one remove from the consultation. Employees experience conflict if their claims are challenged by line managers. However, employers also experience pressure from employees who are desperate not to change or lose their job. Employers
have a duty of care towards employees and should follow employment law to reintegrate them back into the workplace where possible. Employers’ obligations are shaped by governmental policies and law, and whilst companies may have some influence over these via lobbying or organisations such as the CBI, no employers discussed such influence, only how they felt constrained. Hence the diagram above shows there are pressures from the Government towards employers, but not vice versa.

There is a weak relationship between doctors and employers, who in my study (even since the advent of the fit note) rarely communicated in any detail. Wynne-Jones et al. (2010c) reported a related finding, that GPs experienced conflict with employers as they felt their main role as doctor was in tension with what employers wanted from them. The doctors in the study by Wynne-Jones et al. (2010c) were concerned about breaching confidentiality when providing information about functional assessments. However, these doctors were in contact with employers, whereas my empirical work found little employer-doctor contact, apart from fit notes (which were criticised by employers for poor completion and by doctors for not being used in the workplace). Doctors often posited employers as harsh and unaccommodating, whereas employers saw doctors as unrealistic about how workplaces and roles could be adapted. Surrounding all these relationships are social norms, as the Government must be seen to govern wisely and efficiently; doctors to doctor effectively, balancing compassion, patient-centred medicine yet also medical authority; patients and workers must be resilient and get back to work as soon as they can, but not prematurely meaning that they go off sick again; and employers must facilitate individuals’ return to work as much as possible whilst simultaneously remaining focused on the needs of the business. It is not surprising, given this context, that sick-listing and return to work are problematic, and that inappropriate sickness certification often occurs, in which someone whose health outcomes might be better if they worked is signed off, or conversely someone returns to work in a manner which is unsustainable.

10.3b The problems arising from inappropriate sickness certification

I now turn to the problems arising from inappropriate sickness certification. Figure 10.2 shows the main flashpoints:
Fig. 10.2: Flashpoints and problems from inappropriate sickness certification

- **Damaged Relationship**
  - Loss of trust
  - ‘Heart-sink’

- **Conflict DR - Patient**

- **Stigma**
  - Invalidation
    - Diminished Self
    - Spoiled identity

- **Inappropriate Certification**

- **Doctor**

- **Patient Employee**

- **Employer**

- **Presenteeism**
  - Suffering
  - Worsening health
  - Poor performance

- **Not enough Sick Leave**

- **Too much Sick Leave**

- **Medicalisation**
  - Long-term incapacity
  - Dependence on costly benefits
It is well established in the literature that avoiding doctor-patient conflict is a key driver in doctors giving a sick note even when they think one is not medically warranted (e.g. Larsen et al., 1994; Chew-Graham and May, 1999; Englund and Svardssudd, 2000). My findings provided further empirical examples of this happening with chronic pain patients, and showed that doctors find it hard to manage patients who are determined to be sick-listed in the absence of perceived medical need. Many patients were motivated to avoid stigma by gaining state-sanctioned entrance to the sick role and were prepared to challenge doctors to achieve this. Sick notes nominally repaired patients’ sense of self, diminished by the stigma of ill health, and this was an extremely powerful reason for patients to seek the validation of medically authorised sick leave.

The findings gave empirical examples of too much sick leave being given, which could develop long-term incapacity and disengagement from work, which GPs acknowledged. GPs did not use the term ‘medicalisation’ but discussed how they felt their remit was being over-extended and that patients needed more input from other agencies such as social work teams and employment services. Doctors gave good reasons for sick-listing, such as: the need to preserve the doctor-patient relationship for other times the patient would need help; feeling sorry for patients in challenging work and social environments; and being genuinely afraid that sending someone back to work might be harmful to their physical or psychological health, hence it was best to err on the side of caution. Coole et al. (2010a) reported GPs wanted better return to work services; I found GPs wanted this but also wanted better jobs per se for patients to return to, although they were aware this would require large scale societal change. Both patients and doctors discussed how negotiating sick note provision could damage the doctor-patient relationship, as being given a sick note when the doctor did not think it medically warranted only partially enabled enactment of ideal roles.

The findings also gave novel empirical examples of those determined to return to work refusing sick notes, when they really needed time off to recover. These patients engaged in presenteeism, because it fit their self-image and psychological or financial need to continue working. Their health then worsened and they later had to accept sick leave. Whilst these patients were willing to listen to medical opinions, they were prepared to act on their own need to work against GPs’ explicit advice. This was far less damaging to doctor-patient relationships than when patients were posited as supplicants for sick notes against doctors’ judgment. Indeed, as these patients eventually accepted the doctor’s recommendation for sick leave, it more fully restored the ideal doctor and patient roles than when patients got a sick note against the doctor’s initial advice. However, it still caused suffering.

The findings also highlighted conflict between employers and employees over capability and return to work issues. Employers often thought sick leave was inappropriately given, over which they felt powerless, or conversely worried that an employee was back at work before this was sustainable.

Findings from study one suggest that doctors strove to protect the doctor-patient relationship almost at any cost. As it is central to the doctor's habitus, they privileged it above what many saw as policing the healthcare state, and valued it greatly as it is key to making general practice rewarding (Daghio et al., 2003). However, if the doctor and patient disagreed about the capability decision either way, doctors wanted to persuade the patient towards the medical view and if they could not do so without conflict, often nominally accepted the lay view of the problem, although they then worried that the patient’s prognosis might be worsened. The authority of medical knowledge could thus be diminished by GPs’ not wanting to damage the doctor-patient relationship. Chew-Graham et al. (2004) argued that achievement of a satisfactory doctor-patient relationship has been elevated into a primary goal of the consultation, and that this can be harmful. Chew-
Graham et al. (2004) suggested that GPs need to feel powerful enough to advocate strategies that could help to resolve chronic incapacity. My findings suggest this is still problematic for doctors. The change from sick to fit note is trying to shift habitus to doctors being able to challenge patients more but doctors' habitus is also imbued with notions of concordance (Stimson, 1974; Wainwright, 2008) and patient-centred medicine, such the Expert Patient Programmes, giving rise to tensions which are difficult to resolve.

The capability decision was sometimes made easier for doctors by contestable elements of chronic pain as they simply erred on the side of caution and signed people off. However, for many doctors, the indeterminacy of chronic pain highlighted the challenges of the sick-listing consultation to the parameters of medical knowledge. This is the second challenge to medical knowledge, after the sanctity of the doctor-patient relationship took precedence over doctors' opinion a sick note was not medically warranted. To assess chronic pain patients’ functioning, doctors examined people, observing them and listening to them. Some doctors were content to use these methods of assessment, others struggled with subjective elements in line with findings reported by Arrelov et al. (2007). Doctors did not state that chronic pain was more difficult to certify than other conditions which also often rely on patient report such as depression. However, it was a good exemplar of why sick-listing involving MUS is challenging, as doctors have to manage the contestable elements of the condition, translate these into functional assessments, and make a capability decision when they often do not know much about the workplace, and may have to rely solely on patient report for that, too.

Some patients discussed financial imperatives for receiving benefits and how a sick note was important in that regard. Patients were not subject to the same pressure of wanting to preserve the doctor-patient relationship, unless it was a specific doctor that they really trusted.

Patients felt constrained by the organisation of healthcare e.g., having to try to make appointments on a day their pain was bad, or if that was impossible, having to enact pain and incapacity. Doctors reported not believing a few patients but although GPs felt most cases were genuine, patients were sensitised to any hint of being regarded with scepticism and discussed desire for a system which could infallibly weed out the few who taint the many. They acknowledged this was virtually impossible. Patients and doctors expressed unease that sick-listing for chronic pain involves doctors' professional judgements but also patients’ abilities to articulate and enact, which relies on skills that patients may lack through no fault of their own. There is an interesting parallel here between patients' abilities to communicate their pain and justice systems whereby victim statements are used as part of the judicial process. It could be said that both victims and patients with higher levels of articulacy may get more satisfaction out of their particular encounters than those with lower levels, even if the latter group have just as much cause. This is one reason to abide by the dictum “pain is what the patient says it is” (McCaffrey and Beebe, 1989), which indeed the Oxford Handbook of General Practice (2011) suggests, and one reason why asking doctors to reduce sickness certification for chronic pain patients is a far more complex endeavour than it may first appear.

Freidson (1960) highlighted conflict arising from doctors' desire to diagnose and treat whereas patients want their lived experience to be recognised; my findings suggest that patients often want such recognition, but also desire a diagnosis. These wishes are linked, and following Balint (1957), giving the patient a name for their illness could help with both, but patients wanted their diagnosis to be physical rather than psychological, implying the latter could be stigmatising. Patients appeared to want all three elements of the biopsychosocial model to be considered, as they sought recognition of social difficulties such as having to rely too much on family members, and of psychological issues such as depression, but ultimately wanted biomedical treatment and management. My findings
show that applying the biopsychosocial model fully was challenging for GPs, partly as there was uncertainty about where doctors' generalist roles stop and how they can be supported by other services. There is other evidence suggesting that the social element of the biopsychosocial model is difficult to do with chronic pain patients for similar reasons (Harding et al., 2010). Fully applying the biopsychosocial model to effect more appropriate sickness certification is difficult, requiring doctors to embed the consultation in a complex discourse of true holism.

Chronic pain was problematic for patients in the sick-listing consultation, as even within the biopsychosocial framework there was a sense they were being encouraged to confess their problems so the doctor was still ultimately in charge of how medical knowledge was used within the consultation. Foucault (1976) argued that medical discourse was taking over from religiosity as a form of the confessional, in its incitement to disclose, and that this discourse subjects patients to surveillance just as potentially objectifying as biomedicine. Pink et al. (2007) wrote an opinion piece positing that UK GPs encourage confession and society allows this due to the decline in formal religion, but Pink et al. (2007) did not discuss the power relations therein. My findings suggest that doctors and patients were implicitly aware of there being a sense of confession as a discursive type of power. Patients referred to the need to explain the impacts of their pain condition on different areas of their lives (personal, social, occupational). Whilst these explanations had the desired effect of getting patients support, often in the form of a sick note, they also rendered patients weak relative to the professionalism of the doctor. Doctors never explicitly conceptualised interactions as ‘confession’ but simply their status as the person to whom the patient has turned, and some doctors’ encouragement of patients’ narratives, has the tinge of the confessional. However, the modern emphasis on the biopsychosocial encourages talk and narrative, and it is difficult to reconcile this with concerns that consultations provide an arena for confession which is just another way of conceptualising unequal power relations. Also, whilst the chronic pain patients interviewed here experienced conflict with doctors, partly over doctors’ responses to narratives and ‘confessions’, patients could still refuse to follow doctors’ edicts, hence turn away from the confessional constraints. In this way, patient habitus allowed patients some choice within the discourse of modern medicine.

Policy writing might assume that doctors are putting into practice a largely scientific set of judgements about the capability decision (and in some cases this may be so, such as operations with average outcomes and recovery timelines). However, in many cases there is no scientific answer to whether or not a chronic pain patient should be sick-listed. The answer involves some science, and other discourses such as what are the social norms about suffering, what it is to be humane, what it is to be stoical, and all of these are bound up in such a way that it is very difficult to tease them out. Foucauldian analysis might suggest we are constrained by all these different discourses and the value attached to the biomedical model (and now, the biopsychosocial) is such that despite these discourses being particular, historically situated ways of seeing problems and solutions, we accord them status beyond this particularly, assuming they can get at the ‘truth’ of sick-listing.

If a naïve rationalist approach is too simplistic, and sickness certification for chronic pain is not just about implementing an evidence base, then the findings presented in this thesis suggest it is more about moral judgement and the exercise of power. This begins to query the legitimacy of what doctors are doing. Doctors, patients and employers were all aware of the power of being a doctor, and having specific types of medical knowledge, but stakeholders also queried this power, as they recognised that sick-listing is often a social not medical phenomenon. The largely naïve rationalist policy suggests less sick-listing is best for many patients, but when questions of morality, of who is and is not worthy of succour in the form they would like, are present, then sick-listing is at best a double-edged
endeavour. If it is partly a moral decision, being more open about that might help it to become a more effective and understood process.

Parsons (1951) discussed how an ideal type of patient was stoical and resilient. Many had to behave as supplicants who needed to persuade the doctor to sick-list them which caused distress. This was because ideal patients in the modern world are still meant to display Parsonian resilience and are unfairly blamed if they do not (Eccleston et al., 1997; Glenton, 2003) but are also supposed to be active citizens (May, 2006b) engaged in mutually satisfactory shared decision-making with the doctor (Armstrong, 1989). Patients who supplicated and patients who stated that they knew, better than the doctor, how they felt and whether they could work, challenged to these norms. Sensing that they were acting outside their prescribed role, they felt stigmatised, as if they were frauds, felt unpleasant scrutiny from the doctor, and also disapproval from current rhetorical notions of too many people being on benefits instead of at work. These patients challenged the social order of the clinic, which is initially arranged so that patients either obey or at least negotiate with and eventually come to agree with doctors’ views. Seminal work by Strong (1979) showed that doctors have a lot of power over patients even when they strive to be patient-centred e.g. the patient must book the appointment to see the doctor, the time is largely prescribed, the room layout often emphasises the power imbalance, and these structures affected the discourse of the consultation. There is choice for patients over how to behave within the medical system, but their choices can be constrained by the doctor’s role as gatekeeper to sick notes. Findings from my study of doctor-patient interaction support this. For example, one doctor described the theatre of keeping the sick note pad in the drawer, then bringing it out to sit on the desk, as a means of symbolising he had gatekeeping power and was willing to listen and help but in return for certain ideal types of patient behaviour such as the patient actively listening and considering his advice.

Although issuing a sick note left both parties with residual dissatisfaction over how they had enacted their roles in the consultation, it allowed doctors to show compassion and offer some kind of intervention which only medics have the power to give, at least partly restoring their authority. It allowed patients legitimacy and rewarded them for having to behave in ways that made them uncomfortable, such as being in conflict with GPs. Therefore, it is understandable why doctors and patients invest it with such meaning, and why they often resist governmental policy to reduce sickness certification. Resistance against the Government was consciously expressed by some doctors (in common with that reported by Hussey et al., 2004) and also by patients, which I had not found reported in the literature before.

There were also some more practically orientated findings which have implications for policy and research. Doctors expressed conflict between their roles as generalists and also the different specialisms about which they are nowadays required to know: they did not feel they had enough time to find out about the fit note, the national educational programme on work and health and the benefits system. This lack of knowledge appeared to make them less confident but Government attempts to remedy this by simply giving them knowledge had not worked. Doctors wanted on-line interactive modular training which they could do piecemeal as and when. Doctors were unsure where their legal liability lay (at the time of data collection) as the fit note was so new and although the Government’s website and paper documents sent to each practice had stated the fit note had no legal changes from the sick note, doctors had not digested this information. Doctors also thought that employers were not taking their return to work responsibilities seriously.

10.3c The employer dimension: practical findings

Whereas Werner et al. (2012) reported that employers did not want workers back until they were deemed to have fully recovered, in contrast, I found employers agreed in
principle and in practice that people can successfully return to work when less than one hundred per cent fit, and were especially keen to implement this if they valued a particular employee. However, this could be difficult to sustain. Whereas Young and Bhaumik (2011) found SMEs were struggling more than larger companies to implement fit note suggested adaptions, due to lack of role flexibility and OH resources, I found that even very large organisations were finding this difficult. I have not seen this reported elsewhere. Large companies can follow adaptations initially, as they can better absorb their effects elsewhere in the business, but often, employees were unable to move away from these, and employers could not sustain them indefinitely, leading to great conflict between parties.

In line with Goffman’s (1968) work on spoiled identity, I found that employees in all size companies were at risk of being unable to repair their social identity as worker, even when they were recovering and performing well. This was also found in a study on long-term benefit recipients (Wainwright et al., 2012), but to the best of my knowledge has not been reported elsewhere regarding workers.

Both employers and employees, in line with doctors and patients, saw the UK government as a separate entity, often in conflict with them. Employers saw it as too much on the side of ill workers, as employment law was viewed as leaning too heavily towards the medical-therapeutic habitus of keeping people in work at high cost to organisations. However, employees reported they felt too pressurised to go back to work, and censured if they did not recover smoothly.

10.4 Limitations of the thesis

There are several limitations to the empirical studies. These concern the sample composition and size, representativeness and transferability of results, as well as some issues around the design of data collection.

The recruitment methods limit the transferability of the findings. I recruited volunteer participants who tended to be interested in pain, work or both, hence the sampling strategy probably led to systematic bias, as volunteers are known to have certain sets of characteristics (Farmer and Lawrenson, 2004). However, it would have been ethically impossible to recruit non-volunteers and very difficult in practical terms to recruit people uninterested in the topics being researched. Doctors were all from the South-West of England, and it may be that regional norms such as relatively low unemployment affected data collection; a national sample may have rendered the findings more applicable to the UK. However, the other three groups (patients, employers and employees) were recruited both locally and nationally, allowing greater transferability of findings to the rest of the UK.

The small sample sizes followed GTMs principles i.e. I stopped interviewing when I judged saturation had occurred. In this respect, the sample sizes could be viewed positively, since they were consistent with the chosen methods. They do not allow for statistical generalizability but this was not their aim as I was working with qualitative methods, and have attempted to provide a thick description of the participants and their contexts, so that readers could assess whether the findings might be applicable to the populations in which they are interested (Bowling, 2002; Patton, 2002). The findings may be transferable to other contexts, such as sick-listing patients with other chronic and non-specific health complaints (Wessely et al., 1999; Halligan et al., 2003; Wainwright et al., 2006).

An important limitation is that I used self-report data rather than direct observation of doctor-patient interaction. Ideally, I would have liked to interview doctors and patients both before and after observing their consultations. This would not have allowed perfect triangulation as interviews and observations are both social situations affected by the
researcher in different ways (Murphy et al., 1998). Yet observations and interviews of the same individuals would have allowed some comparison of what stakeholders said they experienced in sick-listing with viewing them in the actual situation. This design has been successfully carried out in other areas of general practice e.g. Barry et al. (2003) used it to compare patients’ voiced and unvoiced agenda. Study one asked doctors and patients what they thought of this as a research design, and whilst they were interested in it, most stated it would be unfeasible on practical and ethical grounds. Also, study one data analysis showed it was very important to interview patients in their role as employees, and employers, so this study took precedence over doctor-patient observations within the doctoral time frame.

Similarly, for study two, it would have been useful to undertake ethnographic tracking of the same patients from study one in their role as employee, as they and their line managers negotiated the return to work processes. Although I recruited three employee-employer dyads, none of the study two employees were patients from study one and in hindsight, this would have allowed for a degree of triangulation of the findings. However, at the time of designing study one, the decision to conduct a second study of employees and employers had not been taken, so ethical approval was not sought to follow the same individual all the way through the return to work process. It was a lengthy process to gain NHS ethics approvals for study one, so pragmatically, I decided to save ethnographic tracking as a potential post-doctoral study.

Both studies used several different recruitment techniques for practical reasons; whilst these were largely contemporaneous and not very different (e.g. similar phrasing was used for both online and print versions of study flyers) it is possible that different media attracted different kinds of participants or even set up the interviews to unfold in different ways. For example, I had already met some participants face-to-face at planned events, and established rapport, whereas with others there was only print or email contact prior to interviews (Law, 2012). My opinion is that I was able to establish rapport quickly with the latter group by appropriate interview technique and that the different recruitment techniques did not greatly affect data collection or analysis. However, this cannot be ruled out and it may have been better to recruit using exactly the same method for each study.

The empirical studies used both face-to-face and telephone interviews. Again, although I did not think that this greatly affected data analysis (as I coded without formal reference to it) it may have affected data collection, hence what was there to be analysed. Rubin and Rubin (1995) suggested telephone interviews are inferior to face-to-face regarding ability to establish rapport and detect delicate nuances of non-verbal communication. However, I received positive (unsolicited) feedback from participants from both kinds of interview concerning their research participation, suggesting I had successfully established rapport. Non-verbal cues such as intonation, pauses, repetition etc. were still present in recordings. Immersing myself in the recordings and transcriptions, as well as having done all the interviews myself, assisted in trying to understand the meanings of participants’ words. These things reduced the potential problems of conducting telephone interviews although if the studies were replicated, it may be better to use the same interview technique for all participants. One participant in total (including both studies) asked their partner to be present at a face-to-face interview. I had specified participants would be interviewed face-to-face by one researcher and assumed they would be interviewed alone. This participant’s need for support could not ethically be denied, so their partner attended. It is impossible to say how this participant would have been had they attended alone but it is probable that their partner’s attendance gave them confidence. This eased data collection but also made their interview subtly different from others’. In hindsight, it may have been better to specify in advance that interviews would be one-to-one.
I had a privileged position as interviewer when it came to data analysis. I could remember the context of the data and could access the recordings as well as the transcripts whereas the supervisor who recoded some data only had transcripts. However, it was agreed to do the code-recode element this way for practical reasons, as the supervisor did not have time to listen to the recordings as well as access the transcripts. If the studies had been part of a grant-funded project, perhaps colleagues would have done a larger amount of re-coding, and also listened to the recordings, but for a doctorate, we had to ensure the work remained mine, so only a small amount of recoding was undertaken. This meant there was a tension between my efforts to reduce coding bias by using two coders and how this method actually worked in practice.

10.5 Future research agenda

My empirical work shows strategies to increase trust and communication between stakeholders are key, as recommended by Wynne-Jones et al. (2011) and Black and Frost (2011). However, it is unclear how this might be done effectively, considering the complexity of managing stakeholders’ relationships. I would like to conduct ethnographic tracking of the same patients through initial GP consultations and interactions with their employers, including OH appointments. I would include the design of pre and post consultation interviews, as well as observation of consultations, discussed above. This would allow me to explore in greater depth my findings concerning how the same event (e.g. doctors’ completion of fit notes) is viewed so differently by different parties, leading to tension. I want to research whether following the Dutch model of face-to-face stakeholder communication advocated by Black and Frost (2011) could reduce this tension. I also want to research whether the electronic fit note improves communication, once fully implemented in late 2013 as posited by Black (2008). For example, completing the note electronically may confer higher status than the handwritten version, so doctors might consider their input very carefully and employers respond more positively. The DWP states that they plan to extract anonymous data from the electronic fit note to inform policy development, subject to data security protocols being put in place (DWP, 2012a). This is meant to allow analysis and audit of practice-wide activity, and to inform policy development. I want to research if awareness of such data collection, and later its analysis, affects sick-listing processes at individual and practice level.

I have discussed the importance of repairing the worker’s psychological identity for all stakeholders, and want to research how this might be done. Could its problematic nature be made conscious in return to work plans? Could stakeholders discuss issues around employers showing trust in employees’ ability to take responsibility for their jobs, and employees trusting that employers will truly try to reintegrate them?

My findings reported a minority of doctors trying to access what they termed the narrative essence of patients’ problems, which takes time, but which they saw as a valuable way to practise medicine. My findings suggest that whereas medicine can be very good at fixing bodies and minds, chronic pain frustrates this, and medicine does not often reintegrate people into social networks such as those at work, in a truly holistic manner. If doctors could situate patients’ symptoms within a broader biographical narrative, as suggested by Kleinman (1988) and Bury (1989), would this allow us to understand patients’ life-worlds, and address their return to work problems, more effectively? This is complex and requires more research into how stakeholders invest the tensions between different discourses in general practice, and between medical and workplace knowledge with meaning. To start, it would be useful to trial longer consultations, in conjunction with better training on all parts of the biopsychosocial model, and see if parties felt the capability decision was reached with greater consensus and appropriateness. However, some theorists are concerned about unequal power relations regarding inciting confession in the consultation (Foucault, 1976), as linked to narrative elements of biographical and biopsychosocial models. Armstrong (1987) contends that
medical sociology itself has introduced “the confession, a technique of intimate surveillance...under the guise of progressive humanism...the survey, the questionnaire and the interview all seek to capture the essence of the confession, each methodological debate a fine tuning of the surveillance machinery” (p.71). It may be difficult to research biographical methods within sick-listing consultations without becoming part of the incitement to discourse, so reflexivity will be especially important.

10.6 Implications for policy and practice

Whilst the problems of sick-listing may appear almost intractable, some of the findings have implications for policy--makers, which are considered in the table below.

<table>
<thead>
<tr>
<th>Implication</th>
<th>Example</th>
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<tr>
<td>Acknowledge the complexity of the problem and address the need for cultural change</td>
<td>My findings suggest that by making very difficult issues appear much simpler than they are, policy-makers may alienate stakeholders. I reported that recent policy initiatives focus on GPs’ roles as gatekeepers to sick leave and assume that changing certification rates is relatively straightforward, whereas actually this requires a more fundamental cultural shift that lies largely beyond doctors’ control. Faced by such complexity policy-makers cannot offer a panacea, but they could acknowledge the difficulties of sick-listing more explicitly. Buchbinder (2010) showed that healthcare professionals’ behaviour is complex, and mediated by personal, professional and societal beliefs and norms, and that all these levels need to be tackled simultaneously if change in professional behaviour is to be achieved.</td>
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<tr>
<td>Embed stakeholders’ views more clearly in policy documents</td>
<td>My findings showed that stakeholders agreed work is better than no work in many circumstances but would benefit from their particular points of view being more conspicuously taken on board, to increase ownership of sick-listing and return to work processes. The indeterminacy of chronic pain meant doctors did not respond well to political attempts to impose certainty, in sick-listing and return to work. EBM can be viewed as challenging doctors’ autonomy if seen as a form of bureaucratic rule as it has increased the percentage of elements in medical practice that can be clearly specified with the corollary that the proportion of elements left up to the doctor’s judgment has been reduced. This shifts historical medical and sociology assumptions about medical uncertainty being part of doctoring (Armstrong, 2007; Harrison and Checkland, 2009). The DWP states that they will revise all fit note guidance by the end of 2012 (DWP, 2012a) and there is evidence in other healthcare arenas that taking on board stakeholders’ views does assist with policy implementation (Simmons et al., 2005). If the DWP acknowledged the subjectivity and complexity of many return to work decisions, this may reduce conflict between it and GPs.</td>
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<td>Incentivise doctors to sick-list more effectively</td>
<td>The UK government could incentivise doctors to sick-list less to achieve political aims to reduce sick notes. Harrison and Checkland (2009) show that financial QOF incentives to follow clinical guidelines have had the desired effect. For sick-listing, it may be worth considering whether to add some kind of QOF measure, such as reducing the aggregated number and duration of sick notes given within one practice. However, this assumes that such reduction is the correct way to proceed, and it simply may be inappropriate to make this assumption for one patient, or across a practice’s caseload. Nonetheless, if reduction in sick-listing is what policy-makers want, then a link to the QOF may achieve this. Whether or not it is in patients’ or practitioners best interests is another matter.</td>
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<tr>
<td>Clarity the legal standing of fit note advice and communicate this more clearly through multimedia channels</td>
<td>Employers were worried about the legal implications of return to work processes, although most did not know what the legalities of the fit note are, and had not had time or motivation to find out. Employers also reported that they felt doctors completed fit notes very conservatively as they were also worried about litigation if someone returned to work and claimed their health condition was worsened by this, although doctors did not report this fear. In fact, employers are not legally obliged to act on advice given in the fit note, but many employers’ websites and policy documents follow Chandola (2010) in...</td>
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reasoning that they may be vulnerable to court claims if they do not respond to GPs’ fit note advice, as this may shut down arguments that negative health consequences of work were unforeseeable. The most recent literature search in August 2012 failed to find any case law about fit notes. Although the employers’ DWP fit note guidance states that nothing has legally changed in the move from sick to fit note, policy-makers could consider greatly emphasising this and other legal issues around return to work, using multi-media. Buchbinder et al. (2008) and Buchbinder (2010) showed such campaigns were a good way of publicising new guidelines to stakeholders (in the context of improving back pain management for doctors, patients and employers, which appears transferable to the present context). Clarity may reduce employers’ lack of confidence in responding to fit notes.

| Reduce the external pressures on stakeholders by improving macro level factors | My findings suggest that having better macro structures might help doctors maintain good relationships with patients whilst being able to say no to sick-listing. Doctors discussed that lack of external services from welfare, social and pain management systems, as well as a paucity of good jobs, made them more likely to sick-list, even when they agreed with the concept that work is generally good for patients. Pincus et al. (2010) elicited a similar result, studying private musculoskeletal practitioners. There is a need for policies that encourage employers to improve the quality of working life (Wainwright and Heaver, 2009). This is challenging in the current economic climate but likely to help people to want to return to work. If one takes a long view, then working conditions have greatly improved over the last century but in the shorter term, over the last couple of decades, there has been an increase in what is experienced and labelled as work stress, often attributed to higher productivity demands brought on by modern communication systems not allowing workers to switch off, and poor management-worker relations (Wainwright and Calnan, 2002). If work could be reconceptualised, and in some instances redesigned, perhaps more work would be seen as positive. ICT could be used to allow more autonomy over when and how people work; this happens in some working environments but not in others where it appears feasible (Vilhelmson and Thulin, 2001). Personnel from companies which regularly win awards for creating positive working environments could mentor staff at other companies.

Many patients and employees suggested a macro change needs to be brought about so that there is a social norm about not judging people suffering from chronic illnesses, especially those which may appear invisible. My findings suggest it is virtually impossible to separate the deserving from the undeserving, although that does not stop society from trying (Jackson, 2005; van Oorschot 2000; van Oorschot 2006). It has been argued that there is a point to having stigma, as it functions as a means of social control (Schur, 1984) but mine and many others’ findings report that chronic pain sufferers are stigmatised very easily (Eccleston et al., 1997; Glenton, 2003). It is difficult to reduce stigma although this has happened to some degree with other challenging conditions such as HIV, partly due to extensive multi-media campaigns (Sallar and Somda, 2011). Yet as many editorials on pain have noted, chronic pain does not capture the public imagination in the way that some other conditions do, as it fluctuates, can be invisible and is not life-threatening (Blyth, 2008; Phillips, 2008; Vasu, 2012). Even if moral judgements about pain sufferers could be lessened, we still need to consider how to help the employer who simply cannot accommodate the pain sufferer back into the workplace; the employer may then be subject to moral judgements about their inhumanity, which some study two supervisors were already feeling.

| 10.7 Four radical approaches to improving the problems of sickness certification and return to work for chronic pain patients and stakeholders. |

It may be that more radical approaches to improving the problems discussed are needed; four ideas are presented. The first two were spontaneously discussed by some
doctors, and the third by some employers, whereas the last never arose, perhaps as it is the most radical and people did not know of it or did not consider it relevant to sick-listing.

Firstly, there is the possibility of the Government merging all working-age benefits into a single benefit (Sainsbury and Weston, 2010). This would remove the financial differences between out of work benefits people receive because they are sick and those they receive when they are out of work due to redundancy, or have never found a job. Basic sick benefits are not much more than simple JSA (see appendix one) but can be considerably more when associated sick benefits, to which ESA is a gateway, are added in. Some doctors reported that they would greatly prefer a single benefit system as they would feel under less pressure to certify for financial as opposed to medical reasons. Money et al. (2010) reported that even GPs trained in OH said they felt intimidated into signing sick notes on some occasions, and single benefit welfare reform might reduce at least some kinds of intimidation, as there would be less financial incentive for patients to gain a sick note for benefits. It may be that it is the psychological impetus towards legitimisation of the sick role, rather than financial gain, which propels people to want sick-listing, but this would be useful to know.

Secondly, some researchers (Niven, 2004; Breen, 2007) and opinion pieces by academics and healthcare professionals (Parker, 2008) suggest removing sickness certification from doctors all together. Study one doctors were not directly asked about this but some referred to the debate: none wanted to be relieved of sick-listing all together but many wanted more support for patients from allied professionals such as social workers and benefit agency and rehabilitation staff, to help them sick-list less. Niven (2004) carried out detailed qualitative research into the views of five groups of non-medical healthcare professionals on assessing fitness for work (nurse practitioners in both general practice and A and E; physiotherapists; osteopaths and chiropractors; clinical psychologists and mental health nurses). Niven (2004) reported many practitioners said they would not have difficulty with this if provided with appropriate training. Indeed, many were already asked for advice about returning to work. However, she emphasised that employers, patients and any other stakeholders (such as OH and insurance professionals) would need educating to accept medical practice from a wider group of practitioners. Niven (2004) also argued that even broader systemic aspects, such as collaboration between all these persons, the benefit system and social norms, would have to change so that partnerships could be created with common return to work goals. She did not specify in detail how this could be accomplished, other than making patients more responsible for their health then she found they were back in 2004, and improving communication and provision of support for all stakeholders.

Niven’s work has not been directly referred to in policy papers published so far but some academics (Breen, 2007; Coole 2010a; Thomson and Hampton, 2012) have discussed taking it forward. Thomson and Hampton (2012) reported that a new “assessment of fitness for work” for healthcare professionals other than GPs and hospital doctors is under development at the Department of Health and the Department for Work and Pensions. It will be trialled to see if healthcare professionals such as those suggested by Niven (2004) will be able to formally advise on fitness for work and write fit notes, although it will not allow access to state benefits, for which patients will still have to see a doctor. No more information is currently available on this new version of the fit note, but its appearance meshes with a growing body of opinion that professionals other than GPs are well placed to assist patients in return to work processes. For example, Coole et al. (2010a) researched what GPs do when faced with work problems related to low back pain. They concluded that it is unrealistic of the Government to expect GPs to manage sickness certification differently as GPs lack training, confidence, and also reported a paucity of external services which would make them feel they had something to offer patients other than a sick note. Coole et al. (2010a) suggested that “it might be more
appropriate to train other professionals to assess and manage work problems, such as physiotherapist, case managers or line managers" (p.35). On the other hand, some research and opinion pieces by academics (Thomson and Hampton, 2012) and healthcare professionals (O'Donnell, 2004) argue that general practitioners are best placed to sick-list, as they are still the first point of contact for many people seeking advice about health at work. Thomson and Hampton (2012) argue that in addition to GPs, other health professionals should be able to sign sick notes, but that GPs should remain as a key point of contact. Study one doctors suggested this without prompting as a possible solution.

Thirdly, Parker (2008) suggested allowing self-certification for twenty-eight days, arguing essentially that is what happens now, as there is so much certification on demand. Parker suggested that short-term work absence might rise slightly, as people can already self-certify for seven days, and they may take eight or nine. Yet he also suggested that many people who are given four weeks or more may actually return to work sooner as they do not feel obliged to wait until the end of their sick leave period. Workers are not actually obliged to do so now, but many follow the time period strictly, not realising it can be changed, and many employers worry about accepting someone back before it expires, in case of later legal issues over illness or injury at work. Parker's suggestion appears challenging as it could be interpreted as showing more latitude than the present system allows which seems against the current political climate. However, it could be piloted and it would be interesting and useful to see if the results agree with his predictions. A few employers suggested this as a way forward, arguing that it would not make matters worse for them, (since they perceived it is too easy to get sick-listed at the moment) and might make things better, by encouraging people to take more responsibility for thinking about their health, as well as allowing those who really are ready to come back sooner than the doctor said to do so, without employee or employer worrying about going against doctors' advice.

The final radical idea is basic income guarantee, proposed by Standing (2004, 2005), Coelho et al. (2010) and Skidelsky and Skidelsky (2012). Briefly, every citizen would receive a guaranteed annual income for life, set at just enough to reasonably live on, without conditionality other than citizenship. This would replace all other means of social security. People who wanted more money could work for it and those who didn’t could live on this social wage. Proponents (including the England and Wales, as well as Scottish, Green Party, and the academics cited above) argue this system would ensure a minimum threshold for all whilst incentivizing individuals to take responsibility for their well-being, and cost less than the current welfare system. Sickness certification would not be needed to access SSP as this would no longer exist, so the number of sick-listing consultations would be reduced, relieving some pressure on the system. If businesses kept their own rules on how private sick pay schemes could be accessed, some of which include having a sick note, then the context in which consultations take place may not change much for ill people who are in employment. Basic income guarantee may discriminate against people who really wanted to work to add to their social wage but were too ill. However, it could be useful to research if it reduced sick-listing for the difficult to identify group whose health outcomes might be improved by working, yet they currently need pressuring to return to the workplace (Black and Frost, 2011).

Conclusion
The desire of successive UK governments to reduce sickness certification and enable more patients with chronic pain to remain in work is a laudable one, that may improve the health and well-being of patients, reduce costs to employers and the tax-payer, and even effect greater social justice, but there is also a potential downside. Not everyone with chronic illness can or should return to work, and measures that oblige them to do so may generate adverse outcomes for the patient, doctor and employer. Moreover, sorting those
who should remain at work from those who should not is a far more complex process than it may appear. Evidence-based practice has a role to play, but the findings of this study suggest that there are other social, economic, and psychological factors that impact on the negotiation of sickness certification. The most recent policy and training materials are beginning to recognise this, emphasising the need to equip GPs with the rhetorical and persuasive skills to address such issues. It is too early to assess whether these measures will be successful, but it seems unlikely that their effects will be maximised unless policy-makers also recognise and address the risks and potential costs that doctors, patients and especially employers can incur in adapting to and managing chronic illness at work. If there is a social good to be achieved from maximising the employment participation of chronic pain patients, then there is also a need to ensure that the costs of achieving this objective are distributed equitably.
References


Appendix 1: Rates of ESA, SSA, IB and JSA as of June 2012

Appendix 1.1: Employment and Support Allowance rates

The amount paid depends on the claimant’s circumstances e.g. household income, pension, savings, and what effect their disability has on their ability to do any work.

Rates
Weekly rate during the assessment phase
The assessment phase rate is paid for the first 13 weeks of your claim while a decision is made on your capability for work through the Work Capability Assessment.

<table>
<thead>
<tr>
<th>Age of claimant</th>
<th>Weekly amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A single person aged under 25</td>
<td>up to £56.25</td>
</tr>
<tr>
<td>A single person aged 25 and over</td>
<td>up to £71.00</td>
</tr>
</tbody>
</table>

Weekly rate during the main phase
The main phase starts from week 14 of your claim, if the Work Capability Assessment shows that your illness or disability does limit your ability to work.

<table>
<thead>
<tr>
<th>Type of group</th>
<th>Weekly amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A single person in the Work Related Activity Group</td>
<td>up to £99.15</td>
</tr>
<tr>
<td>A single person in the Support Group</td>
<td>up to £105.05</td>
</tr>
</tbody>
</table>

Appendix 1.2: Statutory Sick Pay rates

From April 2012, the standard rate for SSP was set at £85.85 a week.

Appendix 1.3: Incapacity Benefit rates

How it works
Incapacity Benefit is paid at three weekly rates:
- short-term (lower) IB is paid for the first 28 weeks
- short-term (higher) IB is paid from weeks 29 to 52
- long-term IB is paid from week 53

How much do you get?
Current weekly amounts

<table>
<thead>
<tr>
<th>Weekly rate</th>
<th>Amount</th>
<th>Amount if you’re over State Pension age</th>
</tr>
</thead>
<tbody>
<tr>
<td>short-term (lower rate)</td>
<td>£74.80</td>
<td>£95.15</td>
</tr>
<tr>
<td>short-term (higher rate)</td>
<td>£88.55</td>
<td>£99.15</td>
</tr>
</tbody>
</table>
You may be able to get extra benefit - an 'age addition' - with your long-term Incapacity Benefit if you were under 45 when you became too ill or disabled to work.
You may be able to get extra benefit for your partner, civil partner or the person who looks after your children.

**Appendix 1.4: Jobseeker’s Allowance rates**

From: [http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_200090.html](http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_200090.html) [Accessed 10th June 2012]

**How much will you get paid?**
Depending on your circumstances you may be entitled to the following amounts:

<table>
<thead>
<tr>
<th>Your status</th>
<th>Maximum weekly amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>£56.25</td>
</tr>
<tr>
<td>Over 25</td>
<td>£71.00</td>
</tr>
<tr>
<td>Couples, civil partnerships</td>
<td>£111.45</td>
</tr>
</tbody>
</table>
### Appendix 2: The fit note (statement of fitness for work)


#### Statement of fitness for work

For social security or Statutory Sick Pay

<table>
<thead>
<tr>
<th>Patient's name</th>
<th>Mr, Ms, Miss, Ms</th>
</tr>
</thead>
<tbody>
<tr>
<td>I assessed your case on:</td>
<td>/ /</td>
</tr>
<tr>
<td>and, because of the following condition(s):</td>
<td></td>
</tr>
<tr>
<td>I advise you that:</td>
<td></td>
</tr>
<tr>
<td>you are not fit for work.</td>
<td></td>
</tr>
<tr>
<td>you may be fit for work taking account of the following advice:</td>
<td></td>
</tr>
</tbody>
</table>

If available, and with your employer’s agreement, you may benefit from:

- [] a phased return to work
- [] amended duties
- [] altered hours
- [] workplace adaptations

Comments, including functional effects of your condition(s):

Sample

This will be the case for

or from / / to / /

I will not need to assess your fitness for work again at the end of this period.

(Please delete as applicable)

**Doctor’s signature**

**Date of statement** / /

**Doctor’s address**

Med3 04/10
Appendix 3: Search strategy for literature review

Searches were initially run in December 2008, and the literature review was updated in March 2009, October 2009, January 2010, January 2011, April 2012 (post maternity leave) and August 2012. The earlier, more frequent updates were to familiarise myself with the literature and assist with writing the protocols and other documentation for NHS ethics for the first empirical study. Daily alerts from Web of Knowledge and Zetoc were used throughout the PhD, as were citation alerts via Web of Knowledge and weekly alerts from PubMed. No date limits, language restrictions or document type restrictions were applied to the searches unless otherwise stated.

Cochrane Library

All databases searched using the key word “pain”, then refined by using two key words “chronic pain”
Also searched using the key word “Forestier”
Also searched using the key word “DISH”
Also searched using the key words “diffuse idiopathic skeletal hyperotosis”
Also searched using the key word “CRPS”

EthOS (the British Library’s e-thesis service)

Searched using the key word “pain” then refined by using two key words “chronic pain”.
Also searched using the key word “Forestier”
Also searched using the key word “DISH”
Also searched using the key words “diffuse idiopathic skeletal hyperotosis”
Also searched using the key word “CRPS”

Embase

Searched via the OVID platform, advanced keyword search, not mapped to subject headings:
Search 1: Chronic pain.mp. [mp = title, abstract, subject headings, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword IN EACH mp CASE]
Search 2: sick.mp (not mapped)
Search 3: sickness.mp
Search 4: certificate*.mp
Search 5: certification.mp
Search 6: sickness certification.mp
Search 7: sick leave.mp
Search 8: sick note*.mp
Search 9: sickness absence.mp
Search 10: sick-list*.mp
Search 11: absence.mp
Search 12: work.mp
Search 13: fit note*.mp
Search 14: fit*
Search 15: general practitioner*.mp
Search 16: GP*.mp
Search 17: doctor*.mp
Search 18: incapacity.mp
Search 19: benefit*.mp
Search 20: patient*
Search 21: Forestier*
Search 22: DISH
Search 23: diffuse idiopathic skeletal hypertosis
Search 24: CRPS
Search 25: 1 and 2
International Bibliography of Social Sciences (IBSS)
“chronic pain”
“pain” and “sick*”
“pain” and “work”
“pain” and “doctor”
“pain” and “patient”
NB – this database elicited far fewer results than others (110, 27,207, 28 and 12 respectively in April 2012), so the search was less exhaustive

OPUS (the University of Bath’s electronic research repository)
Searched by Department – three were deemed appropriate (Health, Psychology and Social and Policy Sciences)

PsycINFO
Searched via the OVID platform, advanced keyword search not mapped to subject headings, exactly as for Embase, except keywords.mp = title, abstract, heading word, table of contents, key concepts, original title, tests and measures.

PubMed
Although PubMed is essentially a version of Medline, which Web of Knowledge incorporates, the databases are searchable in different ways, so I used both for the sake of comprehensiveness. PubMed was searched as follows:
No MeSH heading exists for “sickness certification” or “sick note” but these phrases were searched as key words and the MeSH term “sick leave” was searched.
No MeSH heading existed for “chronic pain” until 2012 but the phrase was searched as key words during the PhD in 2008 until 2011. In 2012, “chronic pain” was introduced as a MeSH heading, and was searched including the subheadings economics, ethology, etiology, prevention and control, psychology and rehabilitation.

Social Policy and Practice
Searched via the OVID platform, advanced keyword search not mapped to subject headings, exactly as for Embase, except keywords.mp = abstract, title, publication type, heading word, accession number.

Web of Knowledge
All databases searched, 2006-2012
Search history for list called “SC AND CP oct 09”:

Search 1: Topic = ("sickness certification" OR "sick note" OR "sick-list" OR "sickness absence" OR "incapacity benefit") AND Topic = ("chronic pain" OR "persist* pain" OR "musculoskeletal pain")
Search 2: Title = (sick) AND Title = (pain)
Search 3: Title = (sick) AND Title = (note)
Search 4: Title = (fit) AND Title = (note)
Search 5: Title = (sick) OR Title (fit) AND Title = (note)
Search 6: Title = (sick) OR Title (fit) AND Title = (note) Refined by: Document Type = (REVIEW)
Search 7: Title = (sick) AND Title = (pain)
Search 8: Title = (General practitioner*) AND Title = (chronic pain)
Search 9: Title = (GP) AND Title = (chronic pain)
Search 10: Title = (Doctor) AND Title = (chronic pain)
Search 11: Title = (Forestier*)
Search 12: Title = (DISH)
Search 13: Title = (diffuse idiopathic skeletal hyperostosis)
Search 14: Title = (CRPS)

**Zetoc Alert**

List contents at 240412: the list now contains these journals:

- BMC Family Practice
- BMC Health Services Research
- BMC Medical Education
- BMC Medical Ethics
- BMC Medical Research Methodology
- BMC Musculoskeletal Disorders
- BMC Public Health
- BMC Research Notes
- BRITISH JOURNAL OF GENERAL PRACTICE
- BRITISH JOURNAL OF SOCIAL PSYCHOLOGY
- BRITISH JOURNAL OF SOCIOLOGY
- CLINICAL JOURNAL OF PAIN
- EUROPEAN JOURNAL OF PAIN -LONDON-
- EUROPEAN JOURNAL OF PAIN SUPPLEMENTS
- HEALTH POLICY
- JOURNAL OF HEADACHE AND PAIN
- JOURNAL OF MUSCULOSKELETAL PAIN
- JOURNAL OF PAIN
- JOURNAL OF PAIN AND SYMPTOM MANAGEMENT
- PAIN -AMSTERDAM-
- PAIN MEDICINE
- PAIN PRACTICE
- PAIN RESEARCH AND MANAGEMENT
- SOCIAL POLICY
- SOCIAL POLICY AND SOCIETY
- SOCIAL SCIENCE AND MEDICINE
- SOCIAL SCIENCE RESEARCH

and these searches:

- 1 - "sick" in Title
- 2 - "fit" in Title
- 3 - "pain" in Title
- 4 - "sickness" in Title
• 5 - "absence" in Title
• 6 - "work" in Title
• 7 - "incapacity" in Title
• 8 - "sickness" & "certification" in Title
• 9 - "sickness" & "absence" in Title
• 10 - "sickness" & "certificate" in Title
• 11 - "sickness" & "certificates" in Title
• 12 - "sick" & "leave" in Title
• 13 - "sick" & "note" in Title
• 14 - "fit" & "note" in Title
• 15 - "chronic pain" in Title
• 16 - "fit note" in Title
• 17 - "sick note" in Title
• 18 - "sick leave" in Title
• 19 - "sickness absence" in Title
• 20 - "Forestier" in Title
• 21 – “DISH” in Title
• 22 – "diffuse idiopathic skeletal hyperotosis" in Title
• 23 – “CRPS" in title

There are now 27 journals and 23 searches in the list. Fifty are allowed so the list is at full capacity.
Appendix 4: Conditions studied by Wynne-Jones et al. (2010a) in their report on sickness certification for chronic pain patients
Back pain
Sciatica
Musculoskeletal chest pain
Surgery
Lower limb pain
Osteoarthritis
Elbow pain
General musculoskeletal pain
Foot/ankle pain
Knee pain
Hand pain
Inflammatory arthritis
Neck pain
Upper limb pain
Hip pain
Shoulder pain
Appendix 5: recruitment screening tool for patient participants (study one)

I will now ask you a short series of questions to check that you are eligible to participate in the study. I will write down your answers (which may be just “yes” or “no”) and these answers will be shredded if you are unable to take part in the study.

1. Are you aged 18 or over?

   *If no, don’t recruit. If yes, go to Q2.*

2. Are you in paid employment and have needed a sick note in the last year (including if you are currently on sick leave) OR do you need sick notes for incapacity benefit?

   *If no, don’t recruit. If yes, go to Q3.*

3. In the last year have you had pain in any part of your body that has lasted for three months or more?

   *If no, don’t recruit. If yes, go to Q4.*

4. Are you planning to consult your GP in the next month?

   *If no go to question 5. If yes, go to Q4.1.*

4.1 Will chronic pain be one of the topics you discuss with your doctor?

   *If no, don’t recruit. If yes, go to Q4.2.*

4.2 Do you consider that chronic pain is the major health issue you have to deal with in terms of your (working) life, or at least it is as important as other issues?

   *If yes, recruit. If no, don’t recruit.*

5. Have you consulted your GP in the last year?

   *If no don’t recruit. If yes, go to Q5.1.*

5.1 Was chronic pain one of the topics you discussed with your doctor?

   *If no don’t recruit. If yes, go back to Q4.2.*
Appendix 6: semi-structured interview schedule for GPs

Characteristics of interviewee
- For how many years have you practised as a GP? Do you work full or part-time?
- Would you characterise your practise demographic as urban, rural or mixed?
- Have you had any specialist training in chronic pain management? If so, what?
- Have you had any specialist training in occupational health? If so, what?
- In which country did you study for your primary medical training?

Key issue 1:
Government policy on fit notes
- Are you aware of the introduction of these fit notes?
- Why do you think that the Government is introducing these?
- Are you aware of the evidence behind these notes that work is good for most of us? What do you think about it?
- What do you think about the fit note (electronic and paper)?

Key issue 2:
How do you decide if a chronic pain patient needs a sick note?
- Imagine I’m one of your patients and I present with chronic LBP. I’ve had it before; you’ve investigated and there is no objective pathology. This time, I’ve taken anti-inflammatories for a couple of weeks, and I say that they’ve not worked, that I’m in pain and want to be off work. How do you assess if I need to be off work?
- (How do you make sense of whether or not you think I deserve to be off work?)
- I (the patient) don’t feel I can go to work whereas you do. Would you try to persuade me and if so, how?
- How would you deal with this (with any conflict)?
- Is there anything particular about chronic pain conditions with no evidence of objective pathology (as opposed to other conditions with no objective pathology) which is pertinent to sick note negotiations?

Key issue 3:
Next study (participants are given flow chart of study design which EH briefly explains)
- This is how we plan to identify chronic pain patients with whom you might be discussing sickness certification. Comments/suggestions/anything wrong with this?
- We plan to interview GPs once before a set of consultations was observed, and once again after all the observations. Is this feasible – would you be willing to do this in principle?
- We plan to consent patients in the surgery, before their consultations (ethical approval has recently been given to exactly this process). Comments/suggestions/anything wrong with this?
- We plan to video or audio record consultations. Which would you prefer and why?
- Have you any other practical or ethical comments about the proposed study design?
Summary:
- In terms of sickness certification for chronic pain patients, what is the most important issue for you as a GP?
- Is there anything else about your experiences of sick notes for chronic pain patients that you would like to raise?
- Do you think that efit notes will achieve what the Government intends them to?
- Is there any group of people who you would like to have access to your comments (GPs, the Government, families, other)?

General probes
Elaborative
Can you give me an example of that?
Do you think that this is typical of x?
Can you tell me a bit more about that?
What did you think/feel about that?
Why is that/why do you think that is?

Retrospective
Can I take you back to something you said earlier?
You said…could I ask you a bit more about that?

Comparative
How does that compare with your experience of?
How could things have been different?
What advice would you offer to someone in a similar position to you?
How would you improve x?

Probes for key issue 1:
Government policy on fit notes (Efit notes)
- Any advantages? (record-keeping, communication with stakeholders)
- Any disadvantages? (fraud? time taken to explain to patients? Data going to DWP?)
- Practice staff contributions?
- Are you aware of or using any of the Government’s training and information for GPs on work being good for most people – what do you think about this in relation to chronic pain patients?
- Any advice for policy-makers about the creation and implementation of these/does anyone need to know about the issues we’ve raised?

Probes for key issue 2:
How do you decide if a chronic pain patient needs a sick note?
- How do patients explain the level and nature of their pain? (literal or metaphorical description, statements about functioning etc.)
- How do you decide if patients’ pain is sufficient to keep them off work?
- How problematic do you find it, if at all…
- to assess whether a patient’s functional capacity is reduced?
- to assess the degree to which reduced functional capacity limits a patient’s work ability?
- Are there other factors not do with pain which influence your decisions about whether or not to recommend the patient goes to work? These factors might be about their work (e.g. its type, hours, if they can modify it, relationships at work, their or your feelings about being at their own job or
at work in general, financial considerations) or might be about other issues (e.g. illness or needing to care for someone in the family, childcare, stress not to do with work,) or about co-morbidities?

- How do chronic pain conditions, especially those with no objective pathology, impact upon your sick note negotiations with patients?
- How do you feel about negotiating sick notes?
- Do you know you want to give one out at the start of some consultations?
- Do you feel pressurised into giving out sick notes?
- Do you have to persuade patients to take one up?
- If you do, do you know if they use them?
- How problematic do you find it, if at all…
- to discuss with patients the advantages and disadvantages of being on sick leave?
- to suggest a plan of action and/or measures to be taken during sick leave?
- to manage the two different roles as a patient’s physician and medical expert for the social insurance offices and other authorities?
- (How does your role fit in with that of other service providers?)
- to decide whether to authorize prolongation of a sick leave period that was previously certified by another physician?
- to ascertain the optimum duration and degree of sickness certification?
- Do you negotiate what to put on the sick note with the patient?/tell them/want them to have a lot of input into this?

## Appendix 7: Tests of normality for time practising as GP

### Tests of Normality

<table>
<thead>
<tr>
<th></th>
<th>Kolmogorov-Smirnov&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Shapiro-Wilk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statistic</td>
<td>df</td>
</tr>
<tr>
<td>Timepractisingasgp.</td>
<td>0.190</td>
<td>13</td>
</tr>
</tbody>
</table>

<sup>a</sup> Lilliefors Significance Correction

* This is a lower bound of the true significance.
Appendix 8: semi-structured interview schedule for patients

Characteristics of interviewee
- Can you tell me your gender?
- What is your working status? Full-time, part-time, not working, (if not, why – on sick leave, retired on medical grounds, personal choice, please specify)?
- What is your chronic pain diagnosis and/or how would you describe your condition?
- For how long have you had this pain?

Key issue 1:
Government policy on fit notes
- Are you aware of the introduction of these fit notes?
- Why do you think that the Government is introducing these?
- Are you aware of the ideas behind these notes that work is good for most of us? What do you think about it?
- What do you think/how do you feel about your GP putting you in 1 of these 2 categories?
- What would you think if you came to the GP for a sick note and they ticked the box “you may be fit for work taking account of the following advice”?
- What do you think/how do you feel about taking this note to your employer?
- How would your employer respond if these boxes were ticked suggesting that you need to have your work situation adapted to help you?
- (What do you think about the fit note/electronic and paper version?)

Key issue 2:
What do you consider when deciding if you feel you need a sick note, regarding your pain?
- How do you communicate or describe the level and type of your pain to the GP?
- Have you ever been refused a sick note for a chronic pain condition? How did you feel?
- Have you ever been pressurised into having a sick note – if so, how did you feel and did you actually use it?
- How would you deal with any conflict between you and GPs about sick notes?
- Do you think that your GP takes on board what you’re saying when deciding whether to give you a sick note?
- Does your GP understand you and your work enough to help make decisions about sick notes?
- Do you think that different GPs treat you differently? If so, why?
- (How do you feel about getting or being offered a sick note from your GP?)
- Is there anything particular about your chronic pain condition (as opposed to other conditions) which is especially relevant to our discussions about getting sick notes?

Key issue 3:
Next study (participants are given flow chart of study design which EH briefly explains)
- We plan to interview patients just before a consultation. This might be in the surgery (especially if you’ve booked your appointment that day) or in your home if there was time to arrange this – comments?
- For some patients, we plan to gain their consent as they sit in the surgery before a consultation - comments?
- We plan to audio or video record consultations. Which would you prefer and why?
- We plan to interview patients after the consultation to see how they thought it went (in the surgery/their home/a mutually convenient place). Would you be willing to do this in principle?

**Summary:**
- Is there anything else about your experiences of sick notes for chronic pain conditions that you would like to raise?
- Of all the points made today about chronic pain and sick notes, what would you say is the most important for you as a patient?
- Do you think that efit notes will achieve what the Government intends them to?
- Is there any group of people whom you would like to have access to your comments (GPs, the Government, families, other)?

**General probes**

**Elaborative**
Can you give me an example of that?
Do you think that this is typical of x?
Can you tell me a bit more about that?
What did you think/feel about that?
Why is that/why do you think that is?

**Retrospective**
Can I take you back to something you said earlier?
You said…could I ask you a bit more about that?

**Comparative**
How does that compare with your experience of?
How could things have been different?
What advice would you offer to someone in a similar position to you?
How would you improve x?

**Probes for key issue 1:**

**Government policy on fit notes (Efit notes)**
- Any advantages? (record-keeping, communication with stakeholders)
- Any disadvantages? (fraud? Data going to DWP?)
- Are you aware of any of the ideas and research around work being good for most people, changes to sickness benefits and their tests – what do you think about this in relation to people suffering with chronic pain?
- Any advice for policy-makers about the creation and implementation of these/does anyone need to know about the issues we’ve raised?

**Probes for key issue 2:**

**How do you make sense of whether or not you should be off work?**
- How do you explain to the GP the level and nature of your pain? (do you try to describe the feelings you get, discuss what you can and cannot do, talk about the times your pain is worse, if it fluctuates?)
- How do you decide if your pain is sufficient to keep you off work? Are there specific factors to do with pain that help with this decision?
- How do you communicate your ideas about this to your GP?
• Are there other factors not do with your pain which influence your decisions about whether or not to go to work? These factors might be about work (e.g. type of work you do, hours you do, if you can modify your work, relationships at work, feelings about being at your own job or at work in general, financial considerations) or might be about other issues (e.g. illness or needing to care for someone in the family, childcare, stress not to do with work) or about other conditions you may also have?
• Do you already have in mind that you want a sick note or does someone else suggest this to you (family, friends, employer, GP, other)?
• Do you know you want a sick note at the start of the consultation?
• In consultations, who suggests it first, you or your GP?
• Is it easy to get a sick note? Have there been problems getting one and if so, what kind of problems?
• Does your GP provide a sick note without your having asked for one (“automatically”) or do you have to ask for it?
• Do you feel pressurised into having one that you don’t want?
• If so, do you use it?
• How do you feel about the role your GP takes? Are there “sides” and if so, is the GP “on your side”? Who is on the “other side”?
• Do you and your GP discuss what to say on the sick note, about your condition/capacity/length of time off work?
• Does what goes on the “diagnosis” part of the note seem OK to you – who decides what to write for this part?
• How do you negotiate a plan of action and/or measures to be taken during sick leave?
• Are there advantages and disadvantages to getting a sick note – if so, what are they?
• If your chronic pain condition has no objective diagnosis of disease, do you think that this impacts on your sick note consultation with your GP?

Appendix 9: Tests of normality for years suffering from chronic pain (patients)

Tests of Normality

<table>
<thead>
<tr>
<th></th>
<th>Kolmogorov-Smirnov&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Shapiro-Wilk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statistic df Sig.</td>
<td>Statistic df Sig.</td>
</tr>
<tr>
<td>Timebeingpainpatient</td>
<td>.147 30 .098</td>
<td>.940 30 .092</td>
</tr>
</tbody>
</table>

<sup>a</sup> Lilliefors Significance Correction
Appendix 10:

Participant information sheet for GPs and GP surgery staff
version 11, 26th Nov 2009

Study on sickness certification for patients with chronic pain in general practice

We would like to invite you to take part in a research study. Before you decide whether
you would like to participate, you need to understand why the research is being done and
what it would involve for you. Please take time to read the following information carefully.
Talk to others about the study if you wish and please do not hesitate to ask us if there is
anything that is not clear or if you would like more information. If you would like to
participate, please return one of the two enclosed informed consent sheets to Ms Elaine
Heaver, the study co-ordinator, using the enclosed stamped, addressed envelope, within
one week of receipt of this information pack. The other consent form is for you to keep for
your own records.

What is the purpose of the study?
The study will explore the view of GPs and GP surgery staff about sickness certification
for chronic pain patients. The aim is to understand how doctors come to issue sick notes
and why, for patients living with chronic pain, and the factors that influence negotiation of
a sick note. The Government recently announced a series of policy initiatives to reduce
sickness certification rates and encourage return to work. These initiatives include a
national education programme for GPs emphasising the health benefits of remaining at
work and the planned introduction of an electronic ‘fit note’, that will aid communication
and emphasise capability for work rather than incapacity. These initiatives are aimed at all
patient groups, but we know little about their appropriateness for chronic pain patients.
The study will assess how appropriate the Government’s current proposals are for chronic
pain patients, and also identify other issues that may need to be addressed to manage
sickness certification for people living with chronic pain.

Why have I been approached?
You have been invited to take part in this study because you are a GP or a member of
staff at a GP surgery who deals in some way with chronic pain patients.

Do I have to take part?
It is up to you to decide. The information sheet describes the study and what your
participation would involve. If you are willing to participate, please sign two copies of the
consent form, to confirm that you understand what participating in the study involves and
that you have voluntarily agreed to take part. Keep one copy for your own records and
return the other to the study co-ordinator. You are free to decline entry to the study or to
withdraw at any time, without giving a reason. You can also request that any data
gathered on you are withdrawn, once the focus group discussions are over. Withdrawal
would not affect the standard of any healthcare you receive.

What will happen if I take part?
We will ask you to attend a focus group discussion, with two researchers and about 5
other GPs and/or GP surgery staff, probably from your own surgery or possibly from other
surgeries. This will last for approximately an hour, and will take place at an agreed time
that is convenient to you, such as at the end of a staff meeting. We may hold the focus
group in one of the GP surgeries to minimise at least some participants’ need to travel. If
this is not possible, we will hold the focus group in a central Bristol or Bath venue that has
disabled parking and access, which is likely to be either St Luke’s church hall, Wellsway,
Bath Bowling Club or Bath Leisure Centre. If you decide to participate, we will contact you
with details of when and where to attend. The researchers will be asking general
questions concerning your views on chronic pain and sick notes. We plan to video the
session, although audio recording may be used instead, if this manages the acoustics better, and the researchers may take brief notes. **There is also the option to be interviewed individually in your surgery if you prefer.** The researchers are also arranging a separate focus group with chronic pain patients, to ask how they view the sickness certification system. Findings from this focus group can be made available to you if you wish, without any names or information that could identify an individual.

**Are there any advantages or disadvantages to taking part?**

You will receive no direct benefit from taking part, but in the future, GPs and surgery staff who manage chronic pain patients, and the patients themselves, may benefit from our gaining a greater understanding of how sickness certification is negotiated between them. Sometimes, people worry about discussing a topic that could distress them, such as how they feel about managing chronic pain patients. The researchers will never encourage you to talk about something distressing; it is completely up to you what you say. Also, there are some services you can contact if you feel you need more information about a health or emotional issue raised by participating in the study. You can seek the advice of your doctor or NHS Direct for health advice. Alternatively, you can contact Dr David Wainwright, one of the study supervisors, whose contact details are at the end of this letter.

If the focus group occurs at a time and/or place which requires you to travel, your travel expenses will be paid so that you are not out of pocket. The rate for these is 40p per mile if you drive, or the cost of any second class bus or train fares. If a health condition requires you to use a taxi, this will be reimbursed. All research venues will have disabled access and parking. Unfortunately, childcare costs cannot be reimbursed.

**Will my taking part in this study be kept confidential?**

If you consent to take part in this study, the video/audio footage and all data will be handled and stored following ethical and legal guidelines. Only researchers involved in the study, who work at the Bath Centre for Pain Research and the School for Health, at the University of Bath, will have access to the recordings. All video footage will be kept on a password protected computer file, in a secure locked cabinet, in a room only accessible by researchers who have a key pad code. Any personal data on paper will also be kept in this locked cabinet. The video footage will only be used to generate research data for this study, not for any commercial purpose. When the study is written up, quotations from the transcribed recordings may be used, but names and any details that would allow you to be identified will be removed. All personal data will be destroyed after 5 years – anything on paper will be shredded and anything digital will be erased. Confidentiality will only be breached if you disclose that you wish to harm yourself or another person, in which case the researcher would have to pass this information onto a third party. The University has to undergo an audit periodically to comply with research governance guidelines.

**Who has reviewed the study?**

We expect you know that all research in the NHS is looked at by independent group of people, i.e. the Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Bath Research Ethics Committee.

**What will happen after I have participated?**

The data collected will be analysed and a report will be written. It is hoped that the findings will help to inform the knowledge we have about GP-patient interactions and assist policy-makers when they are considering how to improve systems. The data will also be used for a doctorate, and may be published in a peer reviewed journal. If you would like to receive a summary of the research findings when they are written up, please indicate this on the informed consent sheets below and one will be posted or emailed to you.
What if there is a problem?
We do not anticipate any problems with the study. However, if you have concerns about any part of your participation in it, you can contact the study coordinator, Elaine Heaver, at the address below. If you would rather raise your concern with someone not directly involved in the study, you should contact Professor Ken Judge, Head of the School for Health, Norwood House, The University of Bath, BA2 7AY. Tel 01225 384809 or email: k.f.judge@bath.ac.uk. Alternatively, you can contact Dr David Wainwright, one of the study supervisors, at The School for Health, Norwood House, The University of Bath, BA2 7AY. Tel 01225 385477 or email: d.wainwright@bath.ac.uk. Other services available to you if you wish to discuss a health problem raised by participating in this study include your GP or NHS Direct (0845 4647).

Who is organising and funding the research study?
The research is being organised and funded by the Bath Centre for Pain Research and the School for Health, The University of Bath.

Contact details for further information
We hope that this information sheet has answered any concerns that you may have had. If you require any further information please to not hesitate to ask the study co-ordinator, Ms Elaine Heaver, at: The Bath Centre for Pain Research, Norwood House, The University of Bath, BA2 7AY. Tel: 01225 384047 or email: E.S.Heaver@bath.ac.uk. If you wish to seek general advice about participating in research studies, you may contact Ms Lisa Austin, Research Manager for Pan Bath and Swindon Primary Care Research Consortium at: Norwood House, The University of Bath, BA2 7AY. Tel: 01225 386575 or email L.Austin@bath.ac.uk.

Thank you very much for your time and co-operation
Informed consent sheet for GPs and GP surgery staff to post back to study co-ordinator

Study on sickness certification for patients with chronic pain in general practice

Researcher: Elaine Heaver  Participant number: [for researcher to complete]

Please read and sign both consent sheets, once you are sure you understand what participation involves and have had any queries answered. Keep one and return one to Ms Elaine Heaver, the study co-ordinator, using the enclosed stamped, addressed envelope. If you have mislaid the envelope, the address is: Ms Elaine Heaver, The Bath Centre for Pain Research, Norwood House, The University of Bath, Claverton Down, Bath, BA2 7AY.

Title (Ms, Miss, Mrs, Mr, Dr, Other (please specify)):

Name (please print your full name in block capitals):

Address (please print in block capitals):

Daytime telephone number:

Mobile telephone number:

Email address:

Please tick the following boxes, if the statements are true for you. Please note, you can only participate in the study if all the boxes are ticked.

- [ ] I am 18 or over.
- [ ] I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
- [ ] I understand that my personal data will be kept securely and that anything published will be kept confidential as described in the study information leaflet.
- [ ] I agree to being video or audio recorded and to any audio or video footage being retained in a secure location at the University of Bath for 5 years, after which time it will be destroyed.
- [ ] I confirm that I have read and understood the information sheet (version 11, dated 26th Nov 2009) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- [ ] I would/would not (please delete) like to receive a report on the study findings. I would like to receive this by email/by post (please delete as appropriate).

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Informed consent sheet for GPs and GP surgery staff - for participant to keep

Study on sickness certification for patients with chronic pain in general practice

Researcher: Elaine Heaver

Please read and sign both consent sheets, once you are sure you understand what participation involves and have had any queries answered. Keep one and return one to Ms Elaine Heaver, the study co-ordinator, using the enclosed stamped, addressed envelope. If you have mislaid the envelope, the address is: Ms Elaine Heaver, The Bath Centre for Pain Research, Norwood House, The University of Bath, Claverton Down, Bath, BA2 7AY.

Title (Ms, Miss, Mrs, Mr, Dr, Other (please specify):)

Name (please print your full name in block capitals):

Address (please print in block capitals):

Daytime telephone number:

Mobile telephone number:

Email address:

Please tick the following boxes, if the statements are true for you. Please note, you can only participate in the study if all the boxes are ticked.

☐ I am 18 or over.
☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
☐ I understand that my personal data will be kept securely and that anything published will be kept confidential as described in the study information leaflet.
☐ I agree to being video or audio recorded and to any audio or video footage being retained in a secure location at the University of Bath for 5 years, after which time it will be destroyed.
☐ I confirm that I have read and understood the information sheet (version 11, dated 26th Nov 2009) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
☐ I would/would not (please delete) like to receive a report on the study findings. I would like to receive this by email/by post (please delete as appropriate).

Name of participant Date Signature
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Appendix 11:
Participant information sheet for patients  version 11, 30th April 2010

Study on sickness certification for patients with chronic pain in general practice
We would like to invite you to take part in a research study. Before you decide whether you would like to participate, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish and please do not hesitate to ask us if there is anything that is not clear or if you would like more information. If you would like to participate, please return one of the two enclosed informed consent sheets to Ms Elaine Heaver, the study co-ordinator, using the enclosed stamped, addressed envelope, within one week of receipt of this information pack. The other consent form is for you to keep for your own records.

What is the purpose of the study?
The study is interested in patients’ stories of living with chronic pain and what people think about the current system of getting sick notes. The aim is to understand how and why doctors issue sick notes for patients living with chronic pain. The Government recently announced a series of policy initiatives to reduce sickness certification rates and encourage return to work. These include a national education programme for GPs emphasising the health benefits of remaining at work and the planned introduction of an electronic ‘fit note’. This note is meant to aid communication and emphasise what people can do rather than what they cannot. These initiatives are aimed at all patient groups, but we know little about their appropriateness for chronic pain patients. The study will assess how appropriate the Government’s current proposals are for chronic pain patients, and also identify other issues that may need to be addressed to manage sickness certification for people living with chronic pain.

Why have I been approached?
You have been invited to take part in this study because you have a chronic pain condition. Please check that you can answer “yes” to these questions:
☐ I am over 18, and in paid full or part-time paid employment (this includes people on sick leave)
☐ I have had pain in any part of my body that has lasted for over 3 months, at any point in the last year
☐ I have consulted my GP in the last year or plan to consult within the next month

Do I have to take part?
It is up to you to decide. The information sheet describes the study and what your participation would involve. If you are willing to participate, please sign two copies of the consent form, to confirm that you understand what participating in the study involves and that you have voluntarily agreed to take part. Keep one copy for your own records and return the other to the study co-ordinator. You are free to decline entry to the study or to withdraw at any time, without giving a reason. You can also request that any data gathered on you are withdrawn, once the focus group discussions are over. Withdrawal would not affect the standard of any healthcare you receive.

What will happen if I take part?
You will choose either to have an individual interview or to attend a focus group discussion. If you want to be interviewed individually, this can be over the telephone, or at a convenient venue with disabled access, or in your home, whichever you prefer. If you are interviewed, one researcher will talk with you. If you attend the focus group, it will take place with two researchers and about 5 other chronic pain patients, possibly from your GP surgery or possibly from other surgeries. This will last for approximately an hour, and will
take place during late afternoon/early evening in a neutral space in Bath. This is likely to be either the church hall at St Luke’s in Wellsway, Bath Bowling Club or Bath Leisure Centre. All these places have disabled parking and access. If anywhere else is used, we will ensure that it also has these facilities. If you decide to participate, we will contact you with details of exactly when and where to attend. Refreshments will be provided. The researchers will be asking general questions concerning your views on chronic pain and sick notes. We plan to video the session, although audio recording may be used instead, if this manages the acoustics better, and the researchers may take brief notes. The researchers are also arranging a separate focus group and interviews with GPs and GP surgery staff, to ask how they view the sickness certification system. Findings from this can be made available to you if you wish, without any names or information that could identify an individual.

**Are there any advantages or disadvantages to taking part?**
You will receive no direct benefit from taking part, but in the future patients with chronic pain and their GPs may benefit from our gaining a greater understanding of how sick notes are negotiated. Sometimes, people worry about discussing a topic that could distress them, such as how they feel about their chronic pain condition. The researchers will never encourage you to talk about something distressing; it is completely up to you what you say. Also, there are some services you can contact if you feel you need more information about a health or emotional issue raised by participating in the study. You can seek the advice of your doctor or NHS Direct for health advice. Alternatively, you can contact Dr David Wainwright, one of the study supervisors, whose contact details are at the end of this letter.
Your travel expenses will be paid so that you are not out of pocket. The rate for these is 40p per mile if you drive, or the cost of any second class bus or train fares. If a health condition requires you to use a taxi, this will be reimbursed. All research venues will have disabled access and parking. Unfortunately, childcare costs cannot be reimbursed.

**Will my taking part in this study be kept confidential?**
If you consent to take part in this study, any video/audio footage and all data will be handled and stored following ethical and legal guidelines. Only researchers involved in the study, who work at the Bath Centre for Pain Research and the School for Health, at the University of Bath, will have access to the recordings. All video footage will be kept on a password protected computer file, in a secure locked cabinet, in a room only accessible by researchers who have a key pad code. Any personal data on paper will also be kept in this locked cabinet. The video footage will only be used to generate research data for this study, not for any commercial purpose. When the study is written up, quotations from the transcribed recordings may be used, but names and any details that would allow you to be identified will be removed. All personal data will be destroyed after 5 years – anything on paper will be shredded and anything digital will be erased. Confidentiality will only be breached if you disclose that you wish to harm yourself or another person, in which case the researcher would have to pass this information onto a third party. The University has to undergo an audit periodically to comply with research governance guidelines.

**Who has reviewed the study?**
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by Bath Research Ethics Committee.

**What will happen after I have participated?**
The data collected will be analysed and a report will be written. It is hoped that the findings will help to inform the knowledge we have about GP-patient interactions and assist policy-makers when they are considering how to improve systems. The data will also be used for a doctorate, and may be published in a peer reviewed journal. If you
would like to receive a summary of the research findings when they are written up, please indicate this on the informed consent sheets below and one will be posted or emailed to you.

What if there is a problem?
We do not anticipate any problems with the study. However, if you have concerns about any part of your participation in it, you can contact the study coordinator, Elaine Heaver, at the address below. If you would rather raise your concern with someone not directly involved in the study, you should contact Professor Ken Judge, Head of the School for Health, Norwood House, The University of Bath, BA2 7AY. Tel 01225 384809 or email: k.f.judge@bath.ac.uk. Alternatively, you can contact Dr David Wainwright, one of the study supervisors, at The School for Health, Norwood House, The University of Bath, BA2 7AY. Tel 01225 385477 or email: d.wainwright@bath.ac.uk. Other services available to you if you wish to discuss a health problem raised by participating in this study include your GP or NHS Direct (0845 4647).

Who is organising and funding the research study?
The research is being organised and funded by the Bath Centre for Pain Research and the School for Health, The University of Bath.

Contact details for further information
We hope that this information sheet has answered any concerns that you may have had. If you require any further information please to not hesitate to ask the study co-ordinator, Ms Elaine Heaver, at: The Bath Centre for Pain Research, Norwood House, The University of Bath, BA2 7AY. Tel: 01225 384047 or email: E.S.Heaver@bath.ac.uk. If you wish to seek general advice about participating in research studies, you may contact Ms Lisa Austin, Research Manager for Pan Bath and Swindon Primary Care Research Consortium at: Norwood House, The University of Bath, BA2 7AY. Tel: 01225 386575 or email L.Austin@bath.ac.uk.

Thank you very much for your time and co-operation
**Informed consent sheet for patients - to post back to study co-ordinator**

**Focus group study: Sickness certification for patients with chronic pain in general practice**

**Researcher:** Elaine Heaver  
**Participant number:** [for researcher to complete]

Please read and sign both consent sheets, once you are sure you understand what participation involves and have had any queries answered. Keep one and return one to Ms Elaine Heaver, the study co-ordinator, using the enclosed stamped, addressed envelope. If you have mislaid the envelope, the address is: Ms Elaine Heaver, The Bath Centre for Pain Research, Norwood House, The University of Bath, Claverton Down, Bath, BA2 7AY.

Title (Ms, Miss, Mrs, Mr, Dr, Other (please specify):

Name (please print your full name in block capitals):

Address (please print in block capitals):

Daytime telephone number:

Mobile telephone number:

Email address:

Please tick the following boxes, if the statements are true for you. Please note, you can only participate in the study if all the boxes are ticked.

- [ ] I am 18 or over.
- [ ] I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
- [ ] I understand that my personal data will be kept securely and that anything published will be kept confidential as described in the study information leaflet.
- [ ] I agree to being video or audio recorded and to any audio or video footage being retained in a secure location at the University of Bath for 5 years, after which time it will be destroyed.
- [ ] I confirm that I have read and understood the information sheet (version 11, dated 30th April 2010) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- [ ] I would/would not (please delete) like to receive a report on the study findings. I would like to receive this by email/by post (please delete as appropriate).

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Informed consent sheet for patients - for patients to keep

Focus group study: Sickness certification for patients with chronic pain in general practice

Researcher: Elaine Heaver

Please read and sign both consent sheets, once you are sure you understand what participation involves and have had any queries answered. Keep one and return one to Ms Elaine Heaver, the study co-ordinator, using the enclosed stamped, addressed envelope. If you have mislaid the envelope, the address is: Ms Elaine Heaver, The Bath Centre for Pain Research, Norwood House, The University of Bath, Claverton Down, Bath, BA2 7AY.

Title (Ms, Miss, Mrs, Mr, Dr, Other (please specify):

Name (please print your full name in block capitals):

Address (please print in block capitals):

Daytime telephone number:

Mobile telephone number:

Email address:

Please tick the following boxes, if the statements are true for you. Please note, you can only participate in the study if all the boxes are ticked.

☐ I am 18 or over.
☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
☐ I understand that my personal data will be kept securely and that anything published will be kept confidential as described in the study information leaflet.
☐ I agree to being video or audio recorded and to any audio or video footage being retained in a secure location at the University of Bath for 5 years, after which time it will be destroyed.
☐ I confirm that I have read and understood the information sheet (version 11, dated 30th April 2010) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
☐ I would/would not (please delete) like to receive a report on the study findings. I would like to receive this by email/by post (please delete as appropriate).

Name of participant

Date

Signature
Appendix 12: recruitment poster for patients

Do you have chronic pain that could or does keep you off work?

Would you be willing to discuss your views on living with pain, sick notes and working life, for a research study? We need to know more about the views of people living with pain. You can be interviewed over the phone or in person by a researcher, or can take part in a brief discussion with about 5 others, in a convenient location.

The discussion will take about 1 hour and all expenses will be paid. Refreshments will be provided. Data will be kept confidential.

If you are interested, and aged 18 or over, please contact the study co-ordinator, Elaine Heaver, on (01225) 384047 or E.S.Heaver@bath.ac.uk
Appendix 13: recruitment poster for GPs

What are your views on sickness certification for patients with chronic pain?

The government is trying to change the management of sickness certification but the literature shows this may be difficult, as it can be a challenging area of general practice, particularly for patients with chronic pain.

Research is underway to improve our understanding of social norms surrounding sickness certification for chronic pain patients. Would you be willing to be interviewed at your convenience or take part in a brief focus group session with about 5 others, concerning your views and experiences?

The discussion will take about 1 hour and travel expenses will be paid. Refreshments will be provided. Data will be kept confidential. If you are interested, please complete and return the attached form or contact the study coordinator, Elaine Heaver, on (01225) 385168 or E.S.Heaver@bath.ac.uk

Fold and tear here

PLEASE COMPLETE IN BLOCK CAPITALS
Name: 
Surgery address: 
Email: 
Telephone: 
Comment: 

—End of Recruitment Poster—
Appendix 14: Charity recruitment advertisement for study 09/H0101/72

Version 1  30th April 2010

Please note that the charities’ webmasters or news editors may need to format the advertisement, but the text will be as follows:

Would you be willing to discuss your views on living with pain and working life?

Researchers are looking for people living with pain to discuss how it might affect the ability to work and sickness certification

This will be at your convenience; you can be interviewed either face-to-face or over the telephone, or participate in a local focus group. You might want to discuss experiences with your GP and employer, the new fit note, and benefits. We need to know more about how these issues are negotiated to improve the system.

All data will be kept confidential and all reasonable expenses paid.

If you are interested in finding out more, and are 18 or over, please contact the study co-ordinator, Elaine Heaver, at the Centre for Pain Research, University of Bath (01225) 384047 or esh26@bath.ac.uk
Appendix 15: Participant information pack for employers and employees

Elaine Heaver Wainwright
1 West 3.37, Department for Health
University of Bath
Bath BA2 7AY
(01225) 384047 or esh26@bath.ac.uk

Study on sickness certification from work for people with chronic pain conditions:
participant information sheet version 1, 19th Nov 2010

We would like to invite you to take part in a research study. Before you decide whether you would like to participate, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish and please do not hesitate to contact Elaine Heaver Wainwright, the study co-ordinator, if anything is unclear or if you would like more information. If you would like to participate, please contact Elaine with your address to receive a printed version of this sheet and SAE, so you can sign the consent sheet and return this to her. Or, you if you are happy to do so, please print this version, sign and post to Elaine, or you can scan in your signature and email the signed version to her. There are two consent forms so that you can keep one for your records if you wish.

What is the purpose of the study?
The study is interested in employees' and employers' experiences of managing others' or their own chronic pain conditions in the workplace. The aim is to investigate:
1. Employers' beliefs, aspirations and expectations regarding employees' sick leave for chronic pain conditions and to study their experiences of managing it, with particular reference to the new fit note.
2. Employees' beliefs, aspirations and expectations of having had (or being on) sick leave for a chronic pain condition, with particular reference to the new fit note.

In April 2010, the Government implemented a series of policy initiatives to reduce sickness certification rates and encourage return to work. These include a national education programme for GPs, patient and employers, emphasising the health benefits of remaining at work, and the replacement of the sick note with a new fit note. This note is meant to aid communication and emphasise what people can do rather than what they cannot. These initiatives are aimed at all patient groups, but we know little about their appropriateness for chronic pain patients. The study will consider how appropriate you think the Government’s current proposals are for chronic pain patients, and also identify other issues that may need to be addressed to manage sickness certification for people living with chronic pain.

Why have I been approached?
You are either a manager who has experience of managing sick leave for someone with chronic pain (it does not matter whether you have taken sick leave or not yourself for chronic pain or anything else) or a non-managerial employee who has had, or is taking, sick leave for a chronic pain condition. Chronic pain is defined as pain that lasts over three months, and may involve acute episodes and recurrence as part of its fluctuating nature.

Am I eligible to participate in this study?
Inclusion criteria for participants who are managers.
If you are a manager you must:
• Be 18 years old or over and able to give informed consent i.e. understand and accept the information on these sheets.
• Have some experience of managing sick leave for an employee with chronic pain, as defined above. If the employee has chronic pain but also has other symptoms or
conditions which are more important in terms of how their working life is affected they are not suitable to discuss, although we thank you for your interest.

Inclusion criteria for participants who are employees.
*If you are an employee you must:*
- Be 18 years old or over and able to give informed consent i.e. understand and accept the information on these sheets.
- Be in full or part-time paid employment (including if you are on sick leave).
- Have had a sick note (or the new fit note) for any length of time in the past year. One reason for sickness certification must be that you have, or had, chronic pain i.e. experienced pain in any part of your body that lasted for over three months.
- Please note – if you are an employee who has chronic pain, but also other symptoms or conditions which you feel are more important in terms of how your working life is affected, you are not suitable for this study, although we thank you for your interest.

*If you are manager: you can participate as an individual research subject, or if appropriate, we would really like to disseminate the opportunity to participate in this research to your employees. You may have best practice to share or you may wish to learn more about how sick leave is managed in your company and others. Please contact Elaine if you would like employees to participate (esh26@bath.ac.uk or 01225 384047).*

**Do I have to take part?**
It is up to you to decide. The information sheet describes the study and what your participation would involve. If you are willing to participate, please sign two copies of the consent form, to confirm that you understand what participating in the study involves and that you have voluntarily agreed to take part. Keep one copy for your own records and return the other to the study co-ordinator. You are free to decline entry to the study or to withdraw at any time, without giving a reason. You can also request that any data gathered on you are withdrawn, at any point up to publication. There is no penalty whatsoever if you decide you do not wish to participate at any point.

**What will happen if I take part?**
You will be interviewed for about 40 minutes by a member of the research team, either face-to-face or over the telephone, whichever you choose. If you want to be interviewed face-to-face, the researcher can come to your workplace, your home, or you can visit a University of Bath research venue, with disabled access, according to your preference. If you want to be interviewed at work, it is your responsibility to ascertain that this is acceptable within your workplace. The researcher will ask questions concerning your views on managing or experiencing sick leave for chronic pain and will record the interview. These questions are designed to be inoffensive and of course you can choose to omit any you would prefer not to answer.

**Are there any advantages or disadvantages to taking part?**
You will receive no direct benefit from taking part, but in the future employers and employees may benefit from our having gained a greater understanding of how sick leave for chronic pain is managed. Sometimes, people worry about discussing a topic that could distress them, such as how they feel about their chronic pain condition. The researcher will never encourage you to talk about something distressing; it is completely up to you what you say. Also, there are some services you can contact if you feel you need more information about a health or emotional issue raised by participating in the study. You can seek the advice of your doctor or NHS Direct for health advice. Alternatively, you can contact Dr David Wainwright, one of the study supervisors, whose contact details are at the end of this information sheet. Any travel expenses will be paid so that you are not out of pocket. The rate for these is 40p per mile if you drive and any parking costs incurred, or
the cost of any second class bus or train fares. If a health condition requires you to use a
taxi, this will be reimbursed. Unfortunately, childcare costs cannot be reimbursed.

Will my taking part in this study be kept confidential?
If you consent to take part in this study, the audio recording and all data will be handled
and stored following ethical and legal guidelines. Only researchers involved in the study,
who work at the Bath Centre for Pain Research and the Department for Health, at the
University of Bath, will have access to the recordings. All audio footage will be kept on a
password protected computer file. Any personal data on paper, such as your consent
form, will be kept in a secure locked cabinet. The audio footage will only be used to
generate research data for this study, not for any commercial purpose. When the study is
written up, quotations from the transcribed recordings may be used, but names and any
details that would allow you to be identified will be removed. All personal data (such as
from your consent form) will be destroyed 12 months after the end of the study; anything
on paper will be shredded and anything digital will be erased. Data generated by the study
(such as transcripts) will be destroyed 2 years after it has finished. Confidentiality will only
be breeched if you disclose that you wish to harm yourself or another person, in which
case the researcher would have to pass this information onto a third party.

Who has reviewed the study?
All University of Bath research is looked at by independent group of people, called a
Research Ethics Committee, to protect your interests. This study has been reviewed and
given a favourable opinion by REACH, the Research Ethics Approval Committee for
Health, of the University of Bath.

What will happen after I have participated?
The data collected will be analysed and a report will be written. It is hoped that the
findings will help to inform the knowledge we have about employer-employee interactions
and assist policy-makers when they are considering how to improve systems. The data
will also be used for a doctorate, and may be published in a peer reviewed journal. If you
would like to receive a summary of the research findings when they are written up, please
indicate this on the informed consent sheets below and one will be posted or emailed to
you.

What if there is a problem?
We do not anticipate any problems with the study. However, if you have concerns about
any part of your participation in it, you can contact the researcher, Elaine Heaver
Wainwright, at the address below. If you would rather raise your concern with someone
not directly involved with interviewing, you should contact Dr David Wainwright, one of the
study supervisors, at The Department for Health, 1 West, The University of Bath, BA2
7AY. Tel 01225 385477 or email: d.wainwright@bath.ac.uk. Other services available to
you if you wish to discuss a health problem raised by participating in this study include
your GP or NHS Direct (0845 4647).

Who is organising and funding the research study?
The research is being organised and funded by the Bath Centre for Pain Research and
the Department for Health, The University of Bath. The research team consists of Elaine
Heaver Wainwright (doctoral student), Professor Christopher Eccleston (supervisor and
Director of the Bath Centre for Pain Research), Dr Edmund Keogh (supervisor and senior
lecturer, Dpt. of Psychology), and Dr David Wainwright (supervisor and senior lecturer,
Dpt. for Health).

Please feel free to contact Elaine Heaver Wainwright, the study co-ordinator, for any
further information (contact details are at the top of the first page).
Thank you very much for your time and co-operation.
Informed consent sheet for participants - to post back to study co-ordinator
Study on sickness certification from work for people with chronic pain conditions

Researcher: Elaine Heaver Wainwright
Participant number: [for researcher to complete]

Please read and sign both consent sheets, once you are sure you understand what participation involves and have had any queries answered. Keep one and return one to Ms Elaine Heaver Wainwright, the study co-ordinator, using the enclosed stamped, addressed envelope. If you have mislaid the envelope, the address is: Ms Elaine Heaver Wainwright, The Bath Centre for Pain Research, 1 West, The University of Bath, Claverton Down, Bath, BA2 7AY.
Title (Ms, Miss, Mrs, Mr, Dr, Other (please specify):

Name (please print your full name in block capitals):
Address (please print in block capitals):
Daytime telephone number:
Mobile telephone number:
Email address:

Please tick the following boxes, if the statements are true for you. Please note, you can only participate in the study if all the boxes are ticked.

☐ I am 18 or over.
☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any penalty whatsoever.
☐ I understand that my personal data will be kept securely and that anything published will be kept confidential as described in the study information leaflet.
☐ I agree to being audio recorded and to any audio footage being retained in a secure location at the University of Bath for 2 years after the end of this study, after which time it will be destroyed.
☐ I confirm that I have read and understood the information sheet (version 1, dated 19th Nov 2010) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
☐ I would/would not (please delete) like to receive a report on the study findings. I would like to receive this by email/by post (please delete as appropriate).

Name of participant | Date | Signature
---------------------|------|------------------
---------------------|------|------------------
Name of person taking consent | Date | Signature
---------------------|------|------------------
---------------------|------|------------------
Informed consent sheet for participants to keep

Study on sickness certification from work for people with chronic pain conditions

Researcher: Elaine Heaver Wainwright
Please read and sign both consent sheets, once you are sure you understand what participation involves and have had any queries answered. Keep one and return one to Ms Elaine Heaver Wainwright, the study co-ordinator, using the enclosed stamped, addressed envelope. If you have mislaid the envelope, the address is: Ms Elaine Heaver Wainwright, The Bath Centre for Pain Research, 1 West, The University of Bath, Claverton Down, Bath, BA2 7AY.

Title (Ms, Miss, Mrs, Mr, Dr, Other (please specify):

Name (please print your full name in block capitals):

Address (please print in block capitals):

Daytime telephone number:

Mobile telephone number:

Email address:

Please tick the following boxes, if the statements are true for you. Please note, you can only participate in the study if all the boxes are ticked.

☐ I am 18 or over.
☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any penalty whatsoever.
☐ I understand that my personal data will be kept securely and that anything published will be kept confidential as described in the study information leaflet.
☐ I agree to being audio recorded and to any audio footage being retained in a secure location at the University of Bath for 2 years after the end of this study, after which time it will be destroyed.
☐ I confirm that I have read and understood the information sheet (version 1, dated 19th Nov 2010) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
☐ I would/would not (please delete) like to receive a report on the study findings. I would like to receive this by email/by post (please delete as appropriate).

Name of participant

Date

Signature

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Appendix 16: Recruitment document: “Study on sick leave in the workplace - how access works”

If you are a manager, you do not need anyone’s permission to be interviewed, as all data will be kept confidential and anonymised. Your participation will be independent of your company. The only exceptions to this are:

1. if you wish the interview to be conducted at your workplace. In that case, you will need to ensure this is acceptable
2. if you wish examples of good practice to be associated with your company name, in which case you will need permission of the appropriate person (unless that person is you).

Most interviews are done over the phone, and we can call you at home or on your mobile, at your convenience, although we can also call you at work, provided you have any necessary permission for this. We can interview you in person if you prefer, in a neutral environment or come to your work if appropriate.

If you are a manager and it is appropriate, we would really like to disseminate the opportunity to participate in this study to your employees. You may have best practice to share or you may wish to learn more about how sick leave is managed in your company and others. We have two suggested letters, one coming directly from us and one that is worded to come from you, as some companies have told us that they prefer this. We can come and present our study to any required time limit, if helpful.

If you are an employee, you do not need anyone’s permission to be interviewed, as all data will be kept confidential and anonymised. Your participation will be independent of your company. The only exception to this is if you wish the interview to be conducted at your workplace, in which case you will need permission of the appropriate person (unless that person is you). Most interviews are done over the phone, and we can call you at home or on your mobile, at your convenience, although we can also call you at work, provided you have any necessary permission for this. We can interview you in person if you prefer, in a neutral environment or come to your work if appropriate.
Appendix 17: Recruitment letter for possible interviewees, coming from their manager

Title of potential interviewee: Ms A N Other
Job title: Occupational Health Manager
Work address: Work address

Date

Dear Mr Smith

Company X and the University of Bath are collaborating on research into sickness certification for people suffering from chronic pain conditions (e.g. back pain). If you fit the inclusion criteria in the enclosed study information pack, a University researcher would like to interview you for about 40 minutes, at your convenience, to elicit your views on sick leave, work and health. For example, you may know that the Government has replaced sick notes with fit notes, which are designed to assist the process of returning to work. We are interested in your responses to this, as well as your broader experiences of work, health and well-being. We emphasise that all data will be kept confidential and anonymous so that no individual can be identified.

We hope you will participate in this research by being interviewed. Please read the enclosed study information pack which gives more details. If you have any queries relating to company X, please contact me. If you have queries relating to the management of the study, please contact the researcher, Elaine Heaver, as detailed in the study information pack. A copy of the findings will be made available to you if you wish. If you are happy to participate, please return the attached form to Elaine Heaver by post or email. She will then contact you to set up a suitable time and venue.

Thank you for your interest in this study.

Yours sincerely

Ms A N Other, Head of Occupational Health, Company X
Appendix 18: Recruitment letter for possible interviewees, coming directly from me

Title and name of potential interviewee
Ms Elaine Heaver Wainwright

Job title, if this information is publicly available
Bath Centre for Pain Research

Work address
Department for Health
I West 3.37

University of Bath
Bath

BA2 7AY
(01225) 466077
Esh26@bath.ac.uk

Date

Dear Mr X

The University of Bath is conducting research into sickness certification for people suffering from chronic pain conditions (e.g. back pain). Your company has given permission for the research team to ask if employees are interested in participating in this study. We emphasise that all data will be kept confidential and anonymous so that no individual can be identified. If you fit the inclusion criteria in the enclosed study information pack, we would like to interview you for about 40 minutes, at your convenience, to elicit your views on sick leave, work and health. For example, you may know that the Government has replaced sick notes with fit notes, which are designed to assist the process of returning to work. We are interested in your responses to this, as well as your broader experiences of work, health and well-being.

We hope you will participate in this research by being interviewed. Please read the enclosed study information pack which gives more details. If you have queries, please do not hesitate to contact me. A copy of the findings will be made available to you if you wish. If you are happy to participate, please return the attached form to me by post or email. I will then contact you to set up a suitable time and venue.

Thank you for your interest in this study.

Yours sincerely

Elaine Heaver Wainwright
Bath Centre for Pain Research
Appendix 19: Recruitment document placed on Chamber of Commerce ezine:

MANAGING SICK LEAVE IN THE WORKPLACE

Are you an employer who has managed employee sick leave for any chronic pain condition?

Or

Are you an employee who has experienced sick leave for any chronic pain condition?

Do you have 40 minutes’ spare for an anonymous interview? In return, full study findings will be made available to you so you can see how different organisations manage sick leave and how employees perceive this.

A team at the University of Bath is researching people’s views on sick leave for chronic pain patients. We want to highlight examples of positive experiences, as well as exploring how we can improve things that both employers and employees find difficult. We want to find out what you think of Government policies, especially the new ‘fit note’, in relation to health and well-being in the workplace.

The full study findings will be made available to you, so that you can see how companies manage sick leave and how employees perceive this. All data will be kept anonymous so that no individual or company can be identified in the research report, unless you request otherwise (some companies like their name to be used when discussing their good practice).

In addition to helping us, we hope as participants you will gain a greater understanding of how sick leave for chronic pain is managed within businesses. You will be interviewed for 40 minutes, over the phone or face-to-face, whichever you prefer, at a time and place convenient to you. Reasonable expenses will be paid.

Contact Elaine Heaver Wainwright, tel 01225 384047, esh26@bath.ac.uk to receive full study information.
Appendix 20: Semi-structured interview schedule for employers

Characteristics of interviewee
1. How would you describe the organisation in which you work? E.g. manufacturing, retail, education etc.
2. How many staff does it employ?
3. What is your profession/job title?
4. For how long have you been in this role?
5. How many people do you manage in your team?
6. Can you tell me your gender?

Key issue 1: Employer experience of sick leave for chronic pain
1. Can you talk me through an example of managing sick leave for an employee with a chronic pain condition? What did you personally do and how did any organisational processes affect this?
2. How does your employee communicate their pain condition to you?
3. Are there any issues to do with managing a fit note for a chronic pain condition as opposed to other conditions?
4. Do you and your employee affect negotiations with their GP about whether or not they are signed off?
5. Do your employee’s interactions with their GP affect how you manage their sick leave?

Key issue 2: The fit note
1. Are you aware of the introduction of the fit note? If so, what can you tell me about it? (If not, EH explains fit note, shows a sample and then moves to Q2)
2. What do you think is the rationale behind the fit note?
3. What do you think of the ideas behind the fit note, i.e. that work is good for most of us most of the time and that we do not need to be 100 % fit to return to work?
4. Did you get any training on the fit note? Or give any?
5. What happens to an employee’s fit note when it is given to the company?
6. Do you think that the fit note might change your practice? Have you prepared for the fit note in any way and if so, how? How will you respond if one or more of these boxes are ticked (e.g. that the employee may be fit if they can have amended duties for some time?) What factors influence your response?
7. Can you talk me through an example of managing a fit note for an employee with chronic pain?
8. Are there any advantages to the fit note, as opposed to the sick note, for your company? (show old sick note at this point)
9. Are there any disadvantages to the fit note, as opposed to the sick note, for your company?
10. Might the fit note change your communication with employees, GPs, insurers or any other stakeholders? (e.g. are GPs using the comments box? Is this useful?)
11. Is there anything you would like policy-makers to know about sickness certification?
## Appendix 21: Tests of normality for five employer and employee datasets

<table>
<thead>
<tr>
<th>Tests of Normality</th>
<th>Kolmogorov-Smirnov\textsuperscript{a}</th>
<th>Shapiro-Wilk</th>
</tr>
</thead>
<tbody>
<tr>
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<td>df</td>
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<td>13</td>
</tr>
<tr>
<td>empeyrssuffer</td>
<td>.208</td>
<td>13</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Lilliefors Significance Correction

\textsuperscript{*} This is a lower bound of the true significance.

This shows that two datasets, “no. of years employer has worked in their role” and “no. of years employee has been with their organisation” (called “empyearrole”, “empeyearwkd” and respectively), are normally distributed i.e. the mean and median were not significantly different. In this case, the mean is an appropriate measure of central tendency. For the other three datasets, “no. of people managed by employer”, “no. of people in employee’s team” and “no. of years employee has suffered from chronic pain” (called “nopplmanaged”, “empenoteam” and “empeyrssuffer” respectively), the median is the more appropriate measure of central tendency as the data are not normally distributed.
Appendix 22: Semi-structured interview schedule for employees

Characteristics of interviewee
1. How would you describe the organisation in which you work? E.g. manufacturing, retail, education etc.
2. How many staff does it employ?
3. What is your profession/job title?
4. For how long have you worked in this organisation?
5. Can you tell me your gender?
6. How many people are in your work unit/team?
7. How would you describe your chronic pain condition and for how many years have you had it?
8. Do you work full or part-time (if the latter, is that due to your pain condition) or are you on sick leave at present?

Key issue 1: Employee experience of sick leave for chronic pain
1. Can you give me a brief history of your chronic pain condition, please, and how it now affects your working life. Don’t worry if this takes a while to answer, though you can be as brief or as long as you like.
2. How do you communicate or describe the level and type of your pain to your employers?
3. Do your employers affect your negotiations with your GP about whether or not to get signed off in any way?
4. Do your sick-listing negotiations with your GP affect how the workplace manages sick leave?
5. Do your employers support you, regarding sick leave and return to work? If not, how could they? If they do, are there any other things you’d like done? What about your colleagues?
6. Is there anything particular about your chronic pain condition (as opposed to other conditions) which is especially relevant to our discussions about getting fit notes?

Key issue 2: The fit note
1. Are you aware of the introduction of the fit note? If so, what can you tell me about it? (If not, EH explains fit note, shows a sample, then moves to Q2)
2. What do you think is the rationale behind the fit note?
3. What do you think of the ideas behind the fit note, i.e. that work is good for most of us most of the time and that we do not need to be 100% fit to return to work?
4. What do you think/how do you feel about your GP putting you in 1 of these 2 categories, with reference to your employers seeing the fit note?
5. What do you think/how do you feel about taking this note to your employer?
6. What happens to your fit note when you give it to your employer?
7. How would your employer respond if these boxes were ticked suggesting that you need to have your work situation adapted to help you?
8. Are there any advantages to the fit note, as opposed to the sick note, for you? (show old sick note at this point)
9. Are there any disadvantages to the fit note, as opposed to the sick note, for you?
10. Might the fit note change your communication with employers, GPs, insurers or any other stakeholders?
11. Is there anything you would like policy-makers to know about sickness certification?