

Work-related sickness absence negotiations: GPs' qualitative perspectives

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ABSTRACT

Background

GPs can find their role as issuers of sickness certification problematic, particularly in trying to maintain a balance between certifying absence and preserving the doctor–patient relationship. Little research has been published on consultations in which sickness absence has been certified.

Aim

To explore negotiations between GPs and patients in sickness absence certification, including how occupational health training may affect this process.

Method

A qualitative study was undertaken with GPs trained in occupational health who also participate in a UK-wide surveillance scheme studying work-related ill-health. Telephone interviews were conducted with 31 GPs who had reported cases with associated sickness absence.

Results

Work-related sickness absence and patients' requests for a 'sick note' vary by diagnosis. Some GPs felt their role as patient advocate was of utmost importance, and issue certificates on a patient's request, whereas others offer more resistance through a greater understanding of issues surrounding work and health acquired through occupational health training. GPs felt that their training helped them to challenge beliefs about absence from work being beneficial to patients experiencing ill-health; they felt better equipped to consider patients' fitness for work, and issued fewer certificates as a result of this.

Conclusion

Complex issues surround GPs' role in the sickness-certification process, particularly when determining the patient's ability to work while maintaining a healthy doctor–patient relationship. This study demonstrates the potential impact of occupational health training for GPs, particularly in light of changes to the medical statement introduced in 2010.

Keywords

general practice; occupational health; qualitative research; sickness absence; work-related ill-health.

INTRODUCTION

Medical certification forms part of GPs' contractual service in the UK.¹ Published data on the number of sickness-related certificates are difficult to find; however, GPs are reported to discuss sickness absence in one-third of all consultations,² and issue around 20 sickness certificates per week,³ with one in 10 patients receiving a sickness certificate per year.⁴

Approximately 3 million people of working age in the UK claim sickness benefits,⁵ but only a proportion of absentees are medically unfit for work.⁶ The 2008 Confederation of British Industry survey reported an average of 6.7 days lost per worker to all sickness absence in 2007, at an estimated cost to the UK economy of £20 billion.⁷ In 2007/2008, 2.1 million people self-reported an illness they believed was caused or made worse by their occupation; on average, each person took an estimated 16.9 days off in the previous 12 months.⁸

Data from 2006/2007 in The Health and Occupation Reporting network in General Practice (THOR-GP) showed that musculoskeletal (53.3%) and mental ill-health (29.7%) diagnoses make up the

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How this fits in

There is little published research on what takes place during sickness absence consultations between GPs and patients. This study reports qualitatively on consultations where cases of work-related sickness absence had been certified. The study highlights the importance of patients' views and GPs self-perceived advocacy role in determining the sickness absence advice given, and the value of occupational medicine training for the GP in order to reach, and assert to the patient, a more objective and informed conclusion.

majority of cases, with skin (9.2%), respiratory (3.0%), audiological (0.6%), and 'other diagnoses' (such as lacerations and bruises 4.2%) also being reported.⁹ Just over half the cases were issued with sickness certificates, resulting in 41 288 days of medically-certified absence. A greater proportion of mental ill-health cases were certified sick (78.8%), resulting in 23 099 days, compared to musculoskeletal case reports (42.2%, 14 865 days).

Dame Carol Black's report, and the subsequent government response,¹⁰ encouraged a focus on sickness absence and the reduction of its burden in the UK. It has long been noted that GPs find sickness certification demanding,^{2,11-13} and report a lack of training for this difficult aspect of their day-to-day work.^{14,15} Dame Carol Black's report highlights this problem:

*'GPs often feel ill-equipped to offer advice to their patients on remaining in or returning to work. Their training has to date not prepared them for this and, therefore, the work-related advice they do give, can be naturally cautious.'*¹⁰

UK-based research on sickness absence is generally quantitative in nature, with a much larger body of work in this field originating from Scandinavia.¹⁶⁻¹⁸ Recent UK studies have addressed sickness absence from the perspective of both the

GP¹¹ and the patient.¹⁹ Others have explored long-term sickness absence by identifying individuals receiving benefits or being most at risk in making the transition to long-term incapacity,²⁰ and have focused on the potential influence of patient or GP factors (for example, age and sex) on sickness absence.^{21,22}

Little is known about the negotiations occurring between a patient and GP in sickness absence consultations, and how such negotiations may affect the outcome of certification and the doctor-patient relationship; much of this is due to the occupational history of the patient not being routinely or consistently recorded by GPs.^{2,23} Yet, as previous work has identified, the issue of a medical certificate should be based on both the health problems of the individual and their working conditions.²

The objectives of this study were to report qualitatively on consultations where cases of work-related sickness absence had been certified by GPs trained to diploma level in occupational health. In particular, the study aimed to explore sickness absence negotiations between GPs and patients; the initiation of certification; the influence of occupational health training on interactions; and GPs' role in the certification process and the doctor-patient relationship; and to identify other key issues arising from sickness absence certification due to work-related ill-health.

METHOD

This study involved semi-structured telephone interviews with GPs who reported a case of work-related ill-health to THOR-GP. THOR-GP was established in 2005 as part of The Health and Occupation Reporting network,²⁴ and comprises a UK-wide network of GPs trained in occupational health to diploma level (Diploma of Occupational Medicine/DOccMed, Royal College of Physicians).

The geographical profile of GPs taking part in this study is highly comparable to the coverage of GP practices in the UK: 77% of the GPs were based in England (official GP census data 82%), 3% Northern Ireland (2.5%), 17% Scotland (11%), and 3% Wales (4.5%).²⁵ Preliminary analysis of the population captured by THOR-GP shows it to be nationally representative.²⁶

An interview schedule was drawn up based on issues identified in a literature search of the area, as well as preliminary discussions (pilot interviews) with a number of GPs with reference to standard interview topics (Box 1). Between May 2007 and April 2008 THOR-GP case reports of medically-certified sickness absence were collated. For each week of the study period, the first case reported by a male GP and a female GP were identified.

These GPs were invited to participate in a

Box 1. Main interview topics.

- Background of consultation in which sickness absence was issued
- Who initiates sickness absence certificates? Doctor initiated/patient requested?
- How GPs felt about issuing the sickness absence in that particular case
- Discussion of the GP's role when issuing certificates
- Resistance to the certificate from either doctor or patient
- GPs' expectations about return to work
- Who suggested the work relatedness of the problem?
- How GPs feel generally about their role issuing sickness absence certificates
- Anything else the GP would like to comment on

telephone interview (maximum duration of 15 minutes) at a time/date convenient to themselves. There are well-documented advantages to using telephone interviews in research projects: they are cost-effective, in terms of time and money; cause minimum disruption to the responder; and are extremely flexible.²⁷ The main concern in using telephone interviews relates to quality of data and whether the physical absence of the interviewer is detrimental to the data collected, and that important non-verbal communication and social cues are missed.²⁸ Recent qualitative work has shown these issues can be overcome if some level of responder familiarity is present in the study design (for example, face-to-face recruitment of the responder or, in this case, prior active engagement in a work-related ill-health surveillance scheme) and that, in these instances, telephone interviews can be a useful and successful data-collection tool for qualitative studies.²⁹

A GP was selected for an interview once, and as soon as 'theoretical saturation' was reached³⁰ no further GP interviews were undertaken. All interviews were audio recorded and fully transcribed by the interviewer or a second researcher. Each transcript was read in its entirety by the interviewer and a second research team member, and around 15% of transcripts were also read by a third researcher.

Initial thematic codes were identified from the transcripts; that is, data were indexed to develop analytical categories or thematic codes with which to explore and describe the social phenomena under investigation. Via a process of constant comparison, thematic categories were identified inductively from the interview data;³¹ these analytical categories were subsequently reviewed and refined by the interviewer and second researcher, and any ambiguities in the coding framework were reconciled by thorough discussion. All interviews were then fully coded using NVivo 7 for qualitative analysis.

RESULTS

Thirty-one GPs took part, and one interview did not record properly and was excluded from analysis, resulting in 30 doctor-patient sickness absence summaries. The 30 summaries were associated with 954 days of medically-certified sickness absence (Table 1). Seven principal themes emerged from the interviews (Box 2), and four themes (A/C/D/E) are discussed in this paper:

- A) Initiation/negotiation about sickness absence
- C) Doctor-patient relationship
- D) Occupational health training
- E) Who should administer sickness certification?

A) Initiation/negotiation about sickness absence

The study investigated who suggested/requested sickness absence, and degrees of negotiation therein. In 60% of consultations, patients initiated the request compared to 37% suggested by GPs (3% were continuations of previously certified sickness absence). Fewer certificates were initiated by patients for musculoskeletal disorders (45%) than for mental ill-health issues (71%).

Transcripts reveal the degree of negotiation within consultations:

Int '... who initiated the sickness absence?'

GP2 'She did.'

Int 'Okay, and um ...'

GP2 '... she said that's what she needed and that she wasn't going to leave until she got it.'

Int 'Okay, and how did you feel about that?'

Table 1. Characteristics of cases reported (n = 30) and participating GPs (n = 30).

| | Patient sex | Patient age, years | Number of days certified | GP sex | GP age, years |
|---|-------------|--------------------|--------------------------|---------|---------------|
| Males, n (%) | 11 (37) | | | 20 (67) | |
| Females, n (%) | 19 (63) | | | 10 (33) | |
| Mental ill-health, n = 14 (47%) | F | 59 | 14 | M | 44 |
| | F | 35 | 7 | F | 44 |
| | M | 39 | 14 | M | 41 |
| | M | 41 | 14 | F | 51 |
| | F | 24 | 14 | M | 78 |
| | M | 22 | 11 | M | 44 |
| | M | 61 | 28 | M | 54 |
| | F | 42 | 23 | M | 44 |
| | F | 29 | 7 | M | 45 |
| | F | 58 | 15 | M | 44 |
| | F | 56 | 16 | M | 51 |
| | F | 29 | 14 | F | 40 |
| | M | 46 | 49 | M | 45 |
| | F | 35 | 30 | F | 46 |
| Musculoskeletal disorders, n = 11 (37%) | F | 56 | 7 | F | 44 |
| | F | 26 | 35 | M | 47 |
| | F | 58 | 21 | F | 44 |
| | F | 49 | 16 | F | 42 |
| | F | 20 | 15 | M | 51 |
| | M | 28 | 14 | M | 53 |
| | F | 56 | 20 | F | 50 |
| | F | 63 | 8 | F | 47 |
| | F | 19 | 25 | F | 53 |
| | M | 39 | 21 | M | 45 |
| | M | 52 | 21 | M | 48 |
| Skin disorder, n = 3 (10%) | F | 50 | 10 | M | 51 |
| | M | 18 | 11 | M | - |
| | F | 45 | 7 | M | 50 |
| Respiratory disorder, n = 2 (7%) | M | 58 | 194 | M | 41 |
| | M | 42 | 31 | M | 39 |
| Mean | | 42 | 24 | | 47 |
| Median | | 42 | 15 | | 45 |
| Range | | 18-63 | 7-194 | | 39-78 |

Box 2. Coding frame and principal themes.

- A) Initiation/negotiation about sickness absence
- B) GP's role as patient's advocate
- C) Doctor-patient relationship
- D) Occupational health training
- E) Who should administer sickness certification
- F) Patient's/employers use of sickness certificates
- G) Assigning attribution to work

GP2 'Erm, slightly used.'

This lack of negotiation is apparent in another example:

Int '... OK so who requested the certificate, did the patient ask?'

GP25 'Yes she did.'

Int 'Right, ok.'

GP25 '[Patient was] In tears.'

Examples from consultations where sickness absence is suggested by the GP offer insight into different types of negotiations: one GP suggested joint decision making regarding sickness absence certification:

Int 'Right, okay, and can I ask who initiated the certificate, did you suggest it or did the patient request it?'

GP21 'Um, I don't think she requested it but she did ask me whether I felt she could go to work, um, and I said I didn't think she could.'

Int '... Did the patient initiate the request for sickness absence or did you feel that she should have some time off from work?'

GP23 'It was both, but actually, but she did first say, "I think I'm going to be better with time off", but I, I would have been about a sentence later offering it to her, but she offered, she made the opening.'

C) Doctor-patient relationship

A key concern for many GPs was the conflict between their roles in patient advocacy and sickness absence certification:

GP6 'I think it affects a doctor-patient relationship, and I tend to be, in terms of preserving that, to be on the patients' side. I don't think that it's appropriate for us to be policing social services. My relationship with a

patient is far longer than a short sick note, however, so I tend to give them out. I tend to be on the patients' side of the fence ...'

GP21 '... I used to worry a lot about my role as a GP and whether, the sort of policing aspects of it, um, and I've decided to stop worrying about that because there is very little that I can do about it. So, when a patient asks me for a certificate, obviously I'll have a discussion about why they need it, why they think they need it, and what alternative options there might be. But at the end of the day if they really feel that they can't go to work, I would very rarely say well no, you can't have a certificate, you know, it just compromises the relationship with the patient.'

While many voiced these concerns, others expressed 'resistance to' and/or 'reviewing of' traditional ideas about doctor-patient relationships:

GP22 '... to change the relationship between work and health you must change the culture in which sick notes are issued ... to me the solutions are obvious, and you know, I think that my, you know I've fallen out with other GPs over this because one of the things they say is well, you know, "If you don't give the patient a sick note you don't preserve your relationship with the patient", and I think well what sort of relationship are you preserving though? One that basically says you give them what they want even though you don't think it's what they need, what sort of relationship is that, it doesn't sound like a very good relationship to me ...'

Other GPs resist issuing sickness absence if possible, usually certify for a shorter period than patients request, and promote active management (for example, physiotherapy):

Int '... how do you generally feel about issuing certificates?'

GP9 'Oh, not pleased [laughs].'

Int 'Okay, can you just say a little bit more?'

GP9 'Um, I probably issue the fewest among the partners here I would think, I'm quite harsh. Um, backs [for back pain] and things I try very hard not to issue them unless they can hardly move and then for just a short time and usually get physio involved, we have an in-house physio and so I get them referred to the physio at the same time and tell them to stay mobile and get back to work as soon as you can. So long-term certification, no, not at all keen ...'

Int 'So you tend to resist that then?'

GP9 *'Yes, I am quite resistant I think to issuing certificates on the whole to be fair.'*

Training in occupational health also affects behaviour, and may provide GPs with increased ability to question the nature of a patient's work and whether adjustments could be made to keep the patient in work:

Int *'You said just then about your attitude to issuing certificates has changed since you've done your occupational health training. Can you just tell me a little bit more about that, how has it changed?'*

GP25 *'Well I think you go into it in more detail now, so it's not just accepting what they say, it's finding out what sort of work they do, you know, what their work day entails, what sort of, whether it's physical, whether it's manual or sitting in front of the computer ... and it's finding a way, "Well can we get you back to work, can you discuss with your supervisor to see whether you can do part of your job or can be redeployed elsewhere?". It is just looking at the whole thing rather than here's a sick note for 2 weeks and I'll see you in 2 weeks ...'*

GP28 *'... I'm maybe a little bit unusual among GPs in general, I tend to see an opportunity, I actually quite enjoy doing it, partly because I've got the AFOM [Associateship of the Faculty of Occupational Medicine], I've got more of an interest in it, but as I see it as an opportunity to sometimes challenge people's belief that they need to be off. I tend to, I will very, very rarely will I issue a certificate for more than a month, and I sort of try, my approach is basically try to get people to get back to work as soon as possible ...'*

D) Occupational health training

GPs trained in occupational health are likely to have a better understanding of the interaction between work and health and the benefits of keeping patients in work (in line with government thinking).^{10,32}

GP13 *'... because I've had some occupational health training, I do feel that my role as a GP is definitely as a patient advocate and to do what's in the patients' best interest, I'm quite aware of the issues for the workplace as well because I've had occupational health training, and GPs who haven't had that training might not be aware of, and I think I'm quite on the side of trying to keep people in work where possible, because when they go off, you know, it just gets harder for them to go back, and if you keep going sometimes it's*

the best option for keeping them in work longer.'

GP29 *'[Occupational health training has] made a big difference because I mean, I know we're supposed to be, as GPs, one of the patients' advocates, but I think you've got to look at the overall situation and their wellbeing, you know, people come in with trivial stress-related problems, you start signing them off, they start falling into the sick role, you know, you've got to be very careful doing that and I think we've got to look at the overall picture ...'*

GP15 *'I think sometimes people have too much sickness absence ... I don't think it helps the workforce, and for the finances of the company, or the country, and I also don't think it's that healthy for the people because it puts them into a sick role and destroys the structure of their life ...'*

GPs commented that occupational health training helps them complete certificates more proactively, enabling them to liaise with employers/occupational health departments:

GP2 *'... I have no problems asking if they have got an occupational health department and have they told somebody, and have they talked to them about it ...'*

GP23 *'... quite often I will, after checking with them, deliberately put on the certificate, for instance, work-related stress, to try and get a message to the employer that, you know, she is off with something that they should be knowing about and hopefully doing something about.'*

GP30 *'... I try to give some direction to the person who the sick note is going to, so for example, on her one, I would have written something like, you know, would benefit from seeing occupational health, and that sort of thing, I'd put a comment down like that.'*

In comparison, GPs highlighted how certificates can be abused (by employers and patients):

GP17 *'I get irritated when the companies abuse me and demand sick notes because they're just disciplining their staff after a couple of days, but they're often pretty rubbish companies and I'm wasting my time having a go at them because all they do is take it out on the employee ...'*

GP14 *'If I feel that there is a legitimate medical cause I have no problem, I kind of object to*

issuing medical certificates simply because an organisation cannot get their act together and put methods and systems in place, and that they use a medical certificate or certificates as a way of delaying making a decision ...'

GP24 'Try and encourage them to self-certify for minor illness but they feel under pressure by their employer to substantiate their illness with a doctor's certificate.'

GP11 'At times, if it's an acute or ongoing medical problem, then no problem at all, but sometimes I feel very uncomfortable and that I am being manipulated by patients who I guess have got very poor sick rate records and they really want a certificate because they think it will protect their job ...'

GP29 'I know that some of my patients, because I'm in a large joint practice, some of the patients come back and see another doctor to get the note after they've seen me when I've said no and the other doctor will give it out ...'

GP24 'It can put a strain on the doctor-patient relationship but I think so long as the doctors you're working with are of a like mind, it doesn't do them any good shopping around for a different opinion.'

E) Who should administer sickness certification?

Researchers asked GPs about who should administer sickness absence. One of the three main responses was that GPs should not administer medical certificates at all:

GP12 'The problem with certificates, as it stands, is that the doctor is effectively a gateway to benefits on many occasions, and I know from working in occupational health, from the other side, that at times people will play the system and play one doctor off against the company ... from time to time it crops up, often there are conflicts, often enough you think to yourself, gosh, you know, I wonder why we're doing this at all.'

Second, some GPs believed certification would be easier if GP and occupational health services were combined (although GPs recognised the uneven industrial coverage of occupational health services):

GP25 '... if you'd asked me that before the [occupational health diploma] course, I'd have

said yes, we are the best ones to do that, but when you have to take into account the actual job you do, and actually watching what they do to see whether they are able to do it, I think you probably need a combination of somebody at work and a GP because I don't think there's one person that can take both sides ...'

Finally, some GPs stated they were happy administering sickness absence, and could not identify an alternative. However, training in occupational health remains a key issue:

GP13 '... it's hard to know who else could do it really ... I think it would be better if all GPs had more occupational health training and so could, you know, be better trained in issuing sick notes ... I think if somebody else had to do it, I'm not sure they would be able to, you know, assess the medical side and, and we are uniquely trained in sort of social issues and things as well, so I probably think that, I can't see who else would do it, even though it's a tricky part of our jobs insofar as you know, trying to get, trying to keep the patient working while letting them go off when they need to go off.'

DISCUSSION

Summary of main findings

A qualitative study exploring sickness certification negotiations was undertaken with 30 GPs trained in occupational health and participants in THOR-GP. Some GPs felt their role as patient advocates was of utmost importance and issued certificates on a patient's request; others offer more resistance through a greater understanding of issues surrounding work and health acquired through occupational health training. GPs felt their training helped them challenge beliefs about absence from work being beneficial to patients experiencing ill-health; they felt better equipped to consider patients' fitness for work, and issued fewer certificates as a result.³³

In 60% of consultations, sickness absence was raised by the patient; this happened more frequently in patient with mental ill-health issues than those with musculoskeletal disorders. Transcripts revealed variations in the amount of negotiation taking place between GPs and patients: some GPs felt patients were demanding in their requests for sickness absence (leaving GPs feeling slightly 'used'), while other GPs were happy with the mutual decision making taking place.

GPs had differing opinions on who was best placed to issue certification, ranging from themselves to other individuals who had more

experience of patients' workplaces. GPs also felt the current system was frequently abused by patients who can go to another GP within the practice if refused a sick note, and also by employers who use sick notes to avoid developing systems to assist patients to return to work.

Strengths and limitations of the study

The GPs in this study were sampled from a UK-wide network of GPs all trained in occupational health to DOccMed level, rather than non-occupational health-trained GPs from one geographical area (as is often the case with qualitative research);^{12,19} this may limit extrapolation of results to GPs in general. Additionally, work-related factors are rarely taken into consideration in sickness absence,²¹⁻²³ whereas the interviews in this study were based exclusively on cases of work-related ill-health (not 'all' ill-health), and originated from 'real' consultations rather than simulations.³⁴ Interviews were carried out as soon as possible after the GP submitted a case to THOR-GP (usually within a few days) when the details of the case was still fresh, and aimed to reduce recall bias.

Comparison with existing literature

Research shows that the issuing of a sickness absence certification is dependent on a number of factors, including GP and patient sex²² and diagnosis.⁹ Information available from THOR-GP allowed an adequate representation of male and female GPs, and a representative sample of work-related diagnostics. In this study, sickness absence was requested by the patient in 60% of cases; however, this varied by diagnosis: patients with work-related mental ill-health requested a sick note more frequently than those with musculoskeletal disorders (71% and 45% respectively). Other research has concluded that GPs were more likely to perceive patients with mental ill-health as more ill, less work shy, and more deserving of a sick note than patients presenting with musculoskeletal disorders, and that GPs issued sickness certificates for musculoskeletal disorders primarily to maintain the doctor-patient relationship.³⁵

The present study uncovered varying levels of negotiation in the consultations undertaken by participants in THOR-GP; in contrast a study of 12 general practices in Wales reported that patients' demands for sickness certification had no effect on GPs' beliefs about individual patients, or whether they issued sickness absence.¹⁹ Despite this, GPs find their role in sickness certification a problematic exercise, as found in this study.³⁶ In previous qualitative work, GPs expressed a conflict of interest between the doctor-patient relationship

and certification.^{2,11,12,19,36} In this research, several GPs expressed resistance to the 'traditional' doctor-patient relationship and felt their occupational health training rendered them more aware of the complex issues surrounding work and health (and absence from work), and helped in negotiations during sickness absence consultations. Additionally, contrary to the concerns of GPs regarding conflicting roles (advocate versus 'gatekeeper'), patients did not believe being questioned by/having a discussion with their GP about sickness absence was threatening to the doctor-patient relationship.¹⁹

Awareness of the benefits for patients of staying in work facilitated a proactive approach to sickness certification, (liaising with employers and occupational health services), although clearly THOR-GPs are still issuing certificates for work-related ill-health. Scandinavian research found that GPs with postgraduate training in occupational health tended to issue fewer certificates, and GPs working part-time as industrial medical officers certified significantly shorter periods of absence from work.² These findings would support a policy of better access to specialist occupational health physicians or a multidisciplinary 'fit-for-work' service.¹⁰

With regard to who else could issue sickness certification in the UK, three typical responses were observed: GPs who prefer not to administer certificates, those wanting more involvement from other occupational health agencies, and those happy with the current system but wanting all GPs to have more training in occupational health. These findings reflect those of other researchers.¹²

Implications for clinical practice and future research

Many of the discussion points addressed identify the potential importance of training GPs in occupational health. There is little occupational medical training in general medical education,^{37,38} and only 4% of UK GPs are estimated to have undergone postgraduate training in occupational health.^{39,40} Recent qualitative work identified a consensus among GPs that lack of training in occupational health and certification meant that newly qualified GPs did not believe work-related ill-health issues were of importance.⁴¹ Such findings may impact on the recent introduction of the Med 3 sickness certificate or 'fit note'. As a matter of policy, it is important that GPs have better training in aspects of occupational health, especially in relation to sickness absence and advice relating to the workplace.¹⁰

The findings of this study demonstrate the potential importance of training in occupational

health for all GPs, and the positive finding that GPs are prepared to embrace changes to the sickness certification system to facilitate the reduction of sickness absence. Further work would usefully compare the attitudes of GPs with training in occupational health to those without such training.

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Ethics committee

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Competing interests

The authors have stated that there are none.

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