Case-specific colleague guidance for general practitioners’ management of sickness absence

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Background

General practitioners (GPs) report sickness absence certification as challenging. They express need for support with functional assessment beyond guidelines and reforms. Case-specific collegial one-to-one guidance for other clinical topics has proved popular with GPs and may be an acceptable and effective way to improve GPs skills and competence in sickness absence certification.

Aims

To present a new model of case-specific colleague guidance focusing on the management of long-term sickness absence and to describe its feasibility in terms of application and reception among GPs, and also GPs’ self-reports of effects on their practice.

Methods

Randomly selected GPs received case-specific collegial guidance over a 12-month period, in two Norwegian trials, delivered by former GPs employed by the social security administration. We measured reception and perceived effects by GPs’ self-report and registered participation and withdrawal rates.

Results

The participation rate (n = 165) was 94%, and no GPs withdrew during training. Among the 116 GPs responding to the survey (70%), 112 (97%; 95% CI 92–99) stated they would recommend it to their colleagues. Considerable benefit from the guidance was reported by 68 (59%; 95% CI 50–68). The GPs self-reported other effects on their sickness absence certification, specifically an increased use of part-time sickness absence (Fit-Note equivalent).

Conclusions

This model of case-specific colleague guidance to aid GPs’ management of long-term sickness absence is feasible and was popular. This type of guidance was perceived by GPs to be somewhat beneficial and to alter their sickness absence certification behaviour, though the true impact requires further testing in controlled trials.

Key words

Absenteism; colleague-based guidance; Fit-Notes; general practitioner; occupational health; occupational health physicians; partial sickness absence; sickness absence.

Introduction

In most developed countries, general practitioners (GPs) have a key role in certifying and managing sickness absence [1]. Sickness absence certification can be complex and difficult with GPs feeling they have to satisfy dual roles of patient advocacy and gatekeeping the ‘public purse’ [2,3]. Despite these difficulties, GPs receive relatively little training in sickness absence certification beyond brief introductions to the medico-legal aspects of the system [4]. Some governments have tried to reform the way GPs manage sickness absence in order to increase return-to-work rates. In Norway, a mandatory online course in sick leave certification was rolled out for GPs in 2013, but only slightly >50% completed it [5]. Similar attempts at standard voluntary education of GPs have struggled with even lower participation rates and paradoxical outcomes, with higher levels of sick certification among participants after the course [5]. In 2010, the UK moved from traditional sick certification to...
Statements of Fitness to Work (‘Fit-Notes’), to encourage GPs to consider how patients could remain at work, or return earlier with modified duties [6]. Subsequent evaluations showed that UK GPs still lack confidence in the Fit-Note [7] and the application of guidelines among GPs has been limited [8]. Similar regulations on partial sick leave have been introduced in all Scandinavian countries, but acceptance and utilization among GPs show great variation [9]. GPs often feel challenged by having to consider these options without further support and training [10].

There are different models of GP training. Authoritative clinical guidelines on management of sickness absence have been produced [11], but not very often adopted by GPs [12]. Colleague-based guidance is more popular among GPs [13]; however, there is no specific model on how to implement this for management of sickness certification.

Norwegian GPs are self-employed and reimbursed for each service delivered. The mean number of patients per GP is 1200 and GPs certify 79% of all sickness absence in Norway. A new model for case-specific collegial guidance for GPs with the specific purpose of improving the management of difficult sickness absence cases has been developed. The overall aim of the model is to decrease long-term sickness absence by improving return-to-work rates, thereby reducing the number of patients progressing to long-term financial incapacity benefits. The proposed model’s success and effectiveness depends on its practicality, acceptability and perceived helpfulness by GPs. The model’s efficacy is currently being analysed through sickness absence and disability benefit data from registries 12 and 24 months after the training ended. Preliminary findings indicate conflicting outcomes. One of the two trials has been presented in the Norwegian language by the official Norwegian Labour and Welfare Administration [14], but it is too early to conclude on the efficacy of the model. The aim of this paper is to describe the implementation and feasibility of this model, and GPs’ self-reported change in their clinical management of sickness absence certification.

Methods

The new model of case-specific colleague guidance was consecutively trialled in two areas of Norway: Bergen city and Østfold County, with identical protocols, but different staff at each site. GPs were randomly selected to participate in the trial, with stratified sampling by district and practice.

Seven physicians, three in Bergen and four in Østfold, all employed by the Norwegian social security administration, delivered the guidance intervention. To achieve consistency in the delivery, all seven physicians were equally trained, and regular meetings for coordination of the tutorials were arranged, in Bergen and Østfold separately. In Østfold, all the physicians had a solid background (mean 27 years) in general practice. Only one of the physicians in Bergen had similar background.

Each participant had four 1-h case-specific guidance sessions over 12 months and received standard reimbursement rates and formal recognition of 6-h clinical training. Before each session, the social security administration provided both the GP and the mentor with a list of all patients cared for by the GP who had been on sickness absence for ≥8 weeks. The mean number of patients on these lists was 12, and GPs prioritized which cases to discuss in each session. The guidance sessions did not review GPs’ medical treatment, but emphasized non-medical barriers for return-to-work, such as employers’ ability or willingness to accommodate the patients’ requests for facilitation for return-to-work; workplace conflicts; the patients’ own lack of motivation; avoidant behaviours; or non-medical circumstances in the patients’ lives. The purpose of the guidance programme was to empower the GPs to identify and challenge such barriers for return-to-work, and to help them formulate plans to address these with the patient. The guidance discussed the use of part-time sickness absence (Fit-Note equivalent), to increase GPs’ commitment to the model. Finally, the progress of return-to-work was challenged by discussing GPs’ aspirations for each patient.

We collected GPs’ anonymous self-reports of feasibility, acceptability and changes in sick-listing practices. The survey was distributed by e-mail, with two reminders and ordinary mail. The survey questions were developed by the physicians in the Bergen trial and the Principal Investigator of the project.

The trials were reviewed by the Regional Ethics Committee in Western Norway (2012/1087; 2014/334), the Ombudsman for research at the Norwegian Institute of Public Health (reference 13/284-4/SIKA/TOAM) and www.clinicaltrials.gov (NIPH14-02; NIPH14-12).

Results

Of 176 eligible GPs randomized to the intervention groups, 94% (165) agreed to participate and 70% (116) responded to the survey. None of the 165 GPs withdrew consent to participate with the guidance programme. Non-completion of the programme was due to practical reasons including vacation, own sickness absence, maternity leave and job change. Overall, 93% of GPs completed at least 75% of the programme.

Of the participants, 112 (97%; 95% CI 92–99) stated they would recommend the guidance programme to colleagues, and 83 (71%; 95% CI 63–79) wanted to continue with the programme. Sixty-eight participants (59%; 95% CI 50–68) reported considerable benefits from the programme and 60 (52%; 95% CI 43–61) reported that the programme had made them somewhat more restrictive in their certifying practice. Ninety-nine
(85%) reported that their attention to sickness certification increased, and 72 (62%) reported increased use of part-time sickness certification (Fit-Notes) (Table 1).

More GPs in Østfold were willing to continue the programme than GPs in Bergen (89% versus 54%, Fisher exact test \( P < 0.001 \)). Responders in Østfold consistently responded more positively to the questions, but the differences were not significant.

Discussion

A new model of case-specific colleague guidance to help GPs manage the most challenging sickness absence cases was popular among GPs, who reported appreciating the programme and finding it useful.

The main limitation in this study was the use of self-report measures of perceived benefits and effects. Consequently, we drew no conclusions with respect to efficacy of the model. This will be completed once registry data from the randomized controlled trial are analysed and published. This limitation also precludes economic analysis. Demonstrating economic benefit for this type of intervention will be essential for wider implementation. The proposed model is relatively expensive given its reliance on experienced clinicians providing one-to-one case-specific training. Confidentiality necessitated this one-to-one model, as actual cases from the GPs’ practice were the baseline for the guidance. On the basis of the GPs’ positive statements while piloting the model, we argue that this choice also was crucial for the high participation rate and transparency in the selected case discussions. However, even modest reduction in sickness absence or disability benefits may compensate the expense, which will be analysed once efficacy is established. Given the very high response rate, non-participation bias is unlikely to be a major issue in this analysis, but the anonymous nature of the survey precludes formally testing of this. Both study sites used an identical protocol with physicians delivering the interventions having the same amount of training. However, there were differences in the physicians’ experience in general practice. The impact of these differences will be explored in future trials and focus groups.

Previous attempts to train GPs to modify their sickness absence certification practices have used theoretical courses and few have included clinical interventions with actual patients through supervision or guidance. Reviews of these studies highlight the lack of well-validated tools or procedures to support GPs [4] and of studies of effectiveness, acceptability and cost-benefit [13]. GPs are generally uncomfortable with sickness certification and the assessment of work ability [3,15–17]. Interestingly, despite GPs in this study being very positive about the guidance provided and almost universally stating they would recommend the programme to other GPs, they were more cautious in reporting whether their own behaviour had changed. This may reflect GPs’ awareness of the difficulty in translating knowledge or awareness into behavioural change. Barriers to change were often discussed in the guidance sessions. These might include GPs’ avoidance of conflicts with patients, financial incentives not to lose patients and a perceived lack of cooperation with other stakeholders, such as employers and social security [15]. Change in clinical practice should be

| Table 1. GPs’ views on case-specific colleague guidance of sickness absence management (n (%) and 95% Confidence Interval (CI)) reported 12 months after the programme commenced (n = 116) |
|-------------------------------------------------|--------|--------|--------|--------|--------|--------|
| Considerable | Somewhat | Little or none |
| How would you describe the overall benefits of the case-specific guidance sessions? a | 68 (59) | 45 (39) | 3 (2) | 116 |
| To what extent do you now give increased attention to sickness absence certification? a | 27 (23) | 72 (63) | 17 (15) | 116 |
| Do you think the programme has increased your use of part-time sickness absence (Fit-Notes)? a | 15 (13) | 57 (49) | 44 (38) | 116 |
| Have you become more restrictive in certifying sickness absence? a | 5 (4) | 60 (52) | 51 (44) | 116 |
| Has the contact with officers in the social security improved after the supervision? a | 12 (10) | 42 (36) | 62 (53) | 116 |
| Were four meetings a year suitable? a | Sufficient | 101 (87) | 2 (2) | 13 (11) | 116 |
| | Insufficient | 115 (98) | 1 (1) | 1 (1) | 117 |
| What do you think of 1 hour duration? a | Yes | 83 (71) | 34 (29) | 117 |
| Would you if possible have continued the supervision in another year? | 92–99 | 5 (4) | 6–8 |
| Would you recommend this supervision to your colleagues? | 63–79 | 34 (29) | 21–37 |

aOne of the responders did not answer these questions.
feasible but often requires interactive and repeated training, including discussion and feedback on performance, based on daily clinical practice [12,18].

We have presented a novel model of case-specific colleague guidance to help GPs manage complex sickness absence certification cases. If effective, this type of model could have uses in many different health systems. We have demonstrated that it is feasible and well liked by GPs. This is an essential first step for any primary care intervention. The efficacy of this model now needs testing in well-conducted controlled trials.

Key points

- General practitioners often report finding sickness absence certification challenging, but traditional methods of general practice education and the provision of guidelines have not proved effective in changing clinical practice or patient outcomes.
- We describe a novel model of case-specific colleague guidance to help general practitioners manage complex sickness absence certification cases and demonstrate that the model is feasible to deliver and appreciated by general practitioners.
- Feasibility and acceptability to general practitioners is a necessary first step in any primary care intervention, but these results alone do not demonstrate the effectiveness of the model for improved sickness absence certification.

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Conflicts of interest

None declared.

References


