ORIGINAL ARTICLE

New rules meet established sickness certification practice: A focus-group study on the introduction of functional assessments in Norwegian primary care

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Abstract

Objective. To explore how general practitioners view and handle new standards for functional assessments in sickness certification practice. **Design.** Qualitative study using focus group interviews. Data were analysed according to Giorgi's phenomenological approach and supported by theories on knowledge. **Setting.** General practitioners from three neighbouring counties in Norway. **Subjects.** Four focus groups with a total of 23 participants were recruited through the Norwegian Medical Association and its Continuous Medical Education system. **Results.** The participants reported difficulties and reluctance to act in accordance with new functional assessment demands on both a practical and a conceptual level. In established sickness certification practice functional assessment was described as an unspoken part of the medical examination. After the introduction of formal, written functional assessments they identified problems of terminology, communication, and trust. Strategies were developed to circumvent these problems. **Conclusions.** A gap was noticeable between the participants' established practice and the new standards' demand for a more theoretical and communicative functional assessment. The general lack of training, being confronted with new terminology, and increasingly high pressure to reduce sickness absences create an atmosphere of insecurity when assessing function.

Key Words: *Family practice, focus groups, functional assessment, knowledge, primary care, qualitative study, sickness certification*

General practitioners (GP) have an important role in assessing the need for social benefits in most countries, since illness is a main criterion for allocating these benefits [1,2]. Starting in the UK in 1995, there is now an increasing interest in functional ability as a supplementary criterion to diagnosis [3]. European governments and insurance bodies hope that a focus on functional ability, resources, and coping will improve the handling of individual cases, and reduce the number of people of working age claiming benefits.

In line with these trends, the Norwegian Insurance Scheme introduced new ways to handle sickness absence in 2001 [4]. Employers and employees were explicitly given greater responsibility to reintegrate sick-listed persons, and the earlier focus on disease was supplemented by a functional approach. The

Functional assessments represent a challenge for Norwegian general practitioners. Established certification practice is not easily combined with new standards, and unintended consequences occur.

- New certification standards and focus on functional assessment cause conceptual and practical problems.
- Functional assessment is an implicit part of established certification practice, while new standards require an explicit communication of the assessment's results.
- To change clinical behaviour existing practice must be recognized and consensus reached before major change is initiated.

task of the certifying GP was to assist in this process, and to give an opinion on the employee's functional status in relation to the demands met at work. This stressed the GPs' knowledge of the patient's work assignments, and their ability to map them and to weigh them against the patient's function. From 2002, the Norwegian physicians were requested to give a Simplified Functional Assessment (Forenklet funksjonsvurdering) on sickness certification forms. GPs' comments on functional status were copied and sent to the patient's employer as part of the sickness certification. Employers were to use this information when providing workplace or workload adjustments. A year later, in 2003, information on functional ability was missing in 65% of the sickness certification forms [5], suggesting difficulties in adhering to new standards.

Qualitative research on benefits has focused on certifying procedures [6,7] (e.g. sickness or disability certification system) or on specific diagnoses [8]. These studies suggest that GPs develop strategies when dealing with patients in need of medical certification. Such strategies might be influenced by the length of physicians' professional experience [9]. With the use of quantitative methods, other studies have shown that GPs have difficulties differentiating between functional ability and work ability in their practical work [10–12]. We wanted to examine the GPs' experience of new rules meeting their old practice, and what techniques they use to adjust to change.

Material and methods

The reported qualitative data were collected in a wider study of health care professionals' understanding of function.

A total of 23 general practitioners (19 men and four women) were recruited from urban, suburban, small town, and rural areas, forming four focus groups (group size between four and eight). Participants were recruited through the Norwegian Medical Association, outside the influence of the authors. Three groups were established Continuous Medical Education groups; one group was recruited by invitation. All participants worked as GPs – most in group practices. Two had PhDs, 16 were specialists in general practice, and 5 had no specialist training. The proportion of specialists in this study exceeds the national average (76% vs. 64%) indicating that the participants had longer medical training.

The interviews followed focus group standards with regard to group size, time frame, and moderation [13]. The moderator (SB) used an interview guide with open-ended questions on functional assessment, encouraging participants to discuss

these freely amongst themselves. A social anthropologist researcher (KK) assisted the moderator. The 90-minute-long sessions, conducted in primary care settings, between December 2003 and May 2004, were recorded with the subjects' consent and transcribed in full (KK). Quotations are coded with group number and participant number; for example (group) 1/6 (participant).

The analysis followed Giorgi's phenomenological method [14], as modified by Malterud [15]: (i) Transcripts were read to gain a contextualized impression of the discussions, and preliminary themes chosen. (ii) Units of meaning were identified and coded. (iii) The meaning in the coded groups was condensed. (iv) Descriptions of functional assessment and clinical knowledge were generalized. Data are supported by theoretical perspectives on knowledge [16]. Five themes are discussed here: (i) The tacit assessment, (ii) Wait and see, (iii) Patient confidentiality, (iv) Confusing terminology, and (v) Lacking objective measures. Data on "The concept of function" will be discussed elsewhere.

Results

Dominating all focus group sessions were outspoken frustration, feelings of inadequacy, and discomfort doing functional assessments.

4/4. I say the same as [my colleague]; it's just not my field of expertise! I've no education as to what types of skills or functions are needed in different jobs.

The frustration was embedded in their biomedical training, and in perceived limited knowledge of working life and specific work tasks. Similar arguments were noted in all groups.

The tacit assessment

The participants' professional desire was to follow the customary medical approach of finding a diagnosis, giving a prognosis, and treatment. Assessing function was not described as an important component of a doctor's job in general, but the participants insisted that functional assessment had always been a part of sickness certification practice. Nevertheless they found it difficult to describe the functional assessment as it took place in consultation. It was referred to as being "in the back of our minds" (1/4) and, as in the following dialogue, a part of certification procedures that goes without saying:

2/6. To me this (...) should be obvious. If I assess that a person needs to be certified sick and I actually do

certify – then my whole course of action implies that his functional level isn't consistent with his work (...)

Moderator: Because ... you feel you've already made a decision?

6. Yes, by reaching for the certification form in the first place ...

Moderator: – and at that moment you've already assessed his functional ability, is that what you're saying?

6. Yes! That's what you do: can Peter work or not? (...)

The problem, they maintained, was not the functional assessment per se but rather communicating it to employers and the National Insurance Office. It was argued that “it's difficult to present it on a dotted line” (1/4).

Wait and see

The Simplified Functional Assessment is to be filled out after three days' absence. For most participants a functional assessment at this stage was a waste of the patient's and his/her own time. Instead a time frame was described; function was looked at more actively after some time had passed – six to eight weeks was mentioned – and only if the patient did not follow the pattern the GP predicted.

2/2. You'd expect [the health complaint] to pass reasonably quickly, but then they don't follow that line. That's when you think you have to assess functional ability. (...)

6. Yes, but it's just as much about your gut feeling. If they say that “No, I haven't been to see the physiotherapist, because his waiting list's too long”, right? (...) and the next time they show up then it's not just the old complaints, but a couple of new ones. So this is in the gut – much more than measuring the bending angle of ...

When a health complaint persisted, or a patient did not properly deal with his/her condition, an assessment could be initiated. This assessment was not made explicit to the patient or National Insurance Office – it would still be an implicit part of a medical examination. A few participants indicated that an assessment at this stage had a good psychological effect on patients since the GP could give activity guidelines, and thus make the patient feel more secure regarding his/her own abilities.

Patient confidentiality

Information on patients' health status is strictly confidential [17]. However the patient, is required to inform the employer of functional status so that workplace adjustments can be made. The GP is to assist and guide the patient – and communicate findings to the patient's employer. This could indicate a theoretical difference between information on health and on function. In practice, however, the distinction between health information and functional status information was viewed as undefined and represented possible breaches of patient–doctor confidentiality.

3/1. I would like to point out that I think that the whole system interferes with patient confidentiality. (...) Well, it's something I think is a dilemma.

In some cases the GPs communicated with employers in written form, since written statements could be documented. Oral communication was perceived as impossible:

1/3. I've noticed that the few times an employer has, on his own initiative, called me I clam up and get scared stiff of saying anything at all – because I can't say anything ... actually.

Confusing terminology

On certification forms the terms “functional ability” and “work ability” caused confusion:

4/3. But the linkage between loss of function and work ability? Loss of function in relation to what? You will, as I said, assess loss of function in relation to the patient's work situation – and then, that question [on work ability] seems totally redundant!

Many referred, somewhat humorously, to earlier certification forms where a simple check-list was used to map functional ability.

2/8. It's something about the language that's just hard to grasp, that's what I think.

1. It was easier earlier when there was that check-list – is the patient able to use a knife, hammer, or a saw?

The participants recognized the restricted scope of this check-list, but several used the example to illustrate the simplicity of the language, and to express their call for more adequate terminology in today's system.

Participants reported that this inadequate terminology caused problems in deciding what to write on certification forms. As a consequence some used standard phrases. One participant described filling out a question on correlation between functional ability and work ability: "Well, there is "complete correlation", or (...) I'll write "absolute correlation". Those are the two I have" (3/1). Others would repeat statements from other parts of the form. This was called "cut'n paste". Some would write "see point 1" or "see point 2" referring to a felt repetition of questions in forms.

Lacking objective measures

A final problem discussed among participants was the lack of objective measures to specify work ability. Without objective measures the assessment would be based on the patient's subjective evaluation of his or her own functional status. This could be satisfactory if patients were responsible for their own statements, but the system requires a professional verification of patients' subjective statements, thus leaving the GP with a choice:

1/3. The challenges are largely tied to what you're supposed to do – have faith in the patient or do an independent assessment based on your own opinion?

This was experienced as a trust issue. Certifying absence depending solely on patients' statements often caused feelings of compromising with one's conscience as gatekeeper. To avoid the stress of individual cases some reported acquiescing as a rule. Others argued that their acceptance of patients' subjective descriptions depended on own workload, knowledge of patients' workplace/workload, and patients' medical history. One had a self-constructed form on function, pain, and other issues which he made patients fill out at home. He argued that it gave his certification work structure, saved him time, and allowed him to transfer patients' own statements directly onto the certification form.

Discussion

On the one hand the participants acknowledged functional assessment as part of established certification practice, but it is described in broad terms and as based on a gut feeling. A "wait and see" approach was common; an assessment was normally performed only on long-term sickness absentees or complicated cases. On the other hand they argued that communicating functional assessments according to new standards was practically impossible.

Validity and transferability

We used a qualitative method to investigate a problematic professional issue in family practice. Given that GPs seem more likely to disclose sensitive data when moderated by a peer [18], all sessions were moderated by a GP researcher (SB). Participants in all groups knew each other. Using established groups as focus groups has been discussed [19], and in our case it proved positive. Participants seemed confident in sharing views. The findings are not meant to be facts applicable to a population [20]. Accounts reflect GPs' experience. Patients', employers', or National Insurance Offices' views were not explored. However, information on how new rules are received in established practice should be valuable to health service administrations initiating new standards.

Knowledge and clinical practice

Manoeuvring within the system is a main component in Lipsky's theory on street-level bureaucrats [21]. Participating GPs report strategies that undermine political decisions – expressing a cultural difference between rule-makers and practitioners. Their accounts visualize how function is handled in real-life situations.

Following the GPs' description of established practice a distinction between tacit and explicit knowledge is exposed. Such distinctions have been explored [22] since Polanyi stated: "we can know more than we can tell" [16]. A person may, accordingly, recognize things and even act without being able to explain how and why. Kuhn [23] claims one aspect of tacit knowledge is about having developed "an eye" for certain connections. The notion of clinical knowledge is illustrative: Clinical practice involves more than the application of theoretical knowledge. Prerequisites are also practical skills, sensitivity, and intuition, which incorporate the ability to see the whole situation, contextualize it, and act accordingly [24], thus providing a basis for the concept of tacit knowledge as a form of attention [25]. This was accentuated in the discussion when functional assessment was referred to as a gut feeling. Something catches the clinician's attention; he/she re-evaluates earlier decisions, re-examines the patient, and does a functional assessment. Schön adds another dimension by introducing the term *reflection-in-action*; experienced practitioners act while reflecting on their own knowledge. Illuminating the inherent dynamics of knowledge, Schön argues that new situations can widen the practitioners' field of action [26]. Analogical thinking and judgement are present in this dynamic – as tools to

seek solutions and develop descriptions based on similar and different experiences [27].

Communicating function

The use of standard phrases and “cut’n paste” on certification forms produces information on function that is meaningless to GPs themselves, patients, employers, and case workers. A similar practice is described amongst GPs in the UK [6]. In our case it seemed to serve several purposes. An empty section on certification forms is a negative element; consequently standard phrases support the patients’ rights. The same phrases preserved patient confidentiality, since limited information was passed on to employers. Furthermore, the general practitioner avoids the task of differentiating between work ability and functional ability. He/she also saves time.

The reported need for objective measures can be traced back to a historical divergence between diagnosis and function [28]. While diagnostic issues over time became a matter of credibility and accuracy, function became a matter of subjective opinion. As GPs today are accustomed to legitimizing clinical results within the medical frame of the observable and the measurable, the issue of function has maintained its connection to patients’ subjective experience. Viewing function and subjective opinion as less legitimate and not receiving education on how to communicate functional status creates ambiguity. This is, in our data, reflected in discussions on trusting patients’ statements and objective measures. Similar ambiguity is described elsewhere [6,29,30].

Discussions on objectivity vs. subjectivity and patient confidentiality are well known within the medical professions. The only comparable Norwegian study, a report commissioned by the National Insurance Administration [31], also refers to these issues. A new discussion illustrated in our study is that of inadequate terminology. GPs depend on, and are used to, clear-cut terminology.

Conclusions

Data suggest that GPs know more about functional assessments than they are able to tell. Their knowledge of the area seems so grounded in their practical certification experience that it cannot be expressed in its fullness. This presents us with a gap between their practical knowledge and the demand for a more theoretical and communicative functional assessment. Polanyi’s thesis provides a valuable outlook but the results also mirror the lack of education received on the topic. This lack of training, being confronted with new terminology, and increasingly strong pressure to reduce sickness

absences creates an atmosphere of insecurity when assessing function.

If the National Insurance Scheme wishes to change clinical behaviour it is imperative to recognize existing practices. This means reaching consensus on how to handle patient confidentiality, introducing available theories of function to help deal with problems concerning objectivity, and establishing adequate terminology.

Acknowledgements

The authors would like to thank the general practitioners for participating. The research is funded by the Norwegian Ministry of Labour and Social Inclusion.

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