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# Practices used for recommending sickness certification by general practitioners: A conversation analytic study of UK primary care consultations[☆]

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## ABSTRACT

Existing research indicates that many patients and doctors find the process of negotiating sickness certification for time off work to be a difficult one. This study examined how patients and general practitioners (GPs) managed these negotiations in a sample of UK primary care consultations. The study made use of an existing dataset of audio-recorded consultations between 13 GPs and 506 unselected adult patients in five general practices in London. Forty-nine consultations included discussions for both initial and repeat sickness certification across a wide range of conditions. Here we report our findings on doctor practices for recommending, as opposed to patient practices for advocating for, sickness certification ($n = 26$ cases). All cases were transcribed in detail and analysed using conversation analytic methods. Four main communication practices were observed: (1) declarative statements of need for sickness certification; (2) 'do you need' offers for sickness certification; (3) 'do you want' offers for sickness certification; and (4) conditional 'If X, Y' offers for sickness certification. These different communication practices indexed doctor agency, doctor endorsement and patient entitlement to varying degrees. In the main, recommendations to patients presenting with biomedical problems or a repeat occurrence of a psychosocial problem displayed stronger doctor endorsement and patient entitlement. Contrastingly, recommendations to patients presenting with new psychosocial and biopsychosocial problems, displayed weaker endorsement and patient entitlement. This study offers new evidence to support the Parsonian argument that becoming sick involves entering a social role with special rights and obligations. Through documenting doctors' orientations to their gatekeeping role as well as patients' orientations to differential rights *vis à vis* legitimacy, we demonstrate the contrasting stances of doctors *in situ* when giving sick notes for biomedical problems as opposed to difficulties of a more psychosocial nature.

## 1. Introduction

The foundations of modern day sociological theorizing on health and illness were largely laid by the work of Talcott Parsons (1951), who characterized illness as a deviant behaviour and as a threat to society, due to its ability to halt the fulfilment of social roles. Within his theoretical model, Parsons tempered the influence illness had over society through his formulation of normative, societal roles for both the sick and their physicians; fostering behaviours that facilitated a recovery to health and a reprisal of social roles. For example, while the sick were not to be held responsible for being ill and were to receive societal benefits to support them during their recovery, they were also expected to comply with physicians'

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recommendations and not languish in the comforts that the sick role afforded (i.e. less societal responsibility, access to 'unearned' financial benefits, social and psychological support). To enforce legitimate adoption (and maintenance) of the sick role Parsons gave physicians two roles, firstly: as the agent responsible for transitioning people out of the sick role, back to their former 'healthy' roles (by applying their medical knowledge to the tasks of diagnosis and treatment), and secondly: as a gatekeeper to the societal and financial benefits the sick role affords (Schaefer, 2010). Consequently, within the Parsonian model of society, physicians have a duty to act objectively, on behalf of both the patient and the community (Morgan, 2008).

It has been suggested that this type of affordance of power and responsibility to physicians exposes the patient to social dependencies and vulnerabilities. Access to societal and financial assistance is controlled by physicians (Schaefer, 2010) and, if patients present themselves as sick, but physician opinion differs, others may view the disagreement as evidence of improper behaviour from the 'patient'. For example, such a verdict could suggest that the patient is someone who is over-concerned with their health, a time-waster or someone who is trying to unjustly take advantage of the benefits that the sick role can afford (Heritage and Robinson, 2006). Such patient concerns have been observable in studies exploring patients' accounts for seeking medical help, with patients using various rhetorical devices to 'convince' their doctor that their concerns are legitimate, well-founded and not motivated by self-interest (malingerers), or by a preoccupation with speculative 'signs' of disease (the worried well) (Halkowski, 2006; Heritage and Robinson, 2006).

The Parsonian model for managing illness and the UK's current procedures for managing sickness certification share certain similarities. General Practitioners (GPs) are typically the medical authorities who act as 'gatekeeper' to the sick role. They will often be the first to hear a patient's problem, determine whether it warrants medical attention and if necessary, validate sickness leave from employment through certification. In the UK, self-certification is the correct procedure up until the seventh day of leave (Gov.UK, 2014). However certification from a medical doctor is required after an employee is absent from work for more than seven days in a row (including non-working days).

Parsons discussed a range of costs that sickness can impose on society, including its financial cost (Parsons, 1951). This particular burden on society has been at the forefront of media discussions and policy documents regarding sickness absence in the UK, due to the marked toll it continues to take on the country's economic state. For example, the cost of sickness absence to UK businesses has been reported as being nearly £29 billion a year (PwC, 2013). In terms of costs to individual members of society, prolonged sickness absence has been shown to have severe negative consequences for both the patient and their family (Campbell et al., 2007; Waddell et al., 2007).

In addition, the process of certification itself can cause doctors stress and patients elevated anxiety. Doctor stress can be perpetuated by their perception that sickness certification discussion may lead to conflict with the patient. To prevent this conflict from arising they may strive to protect their primary role as patient advocate, rather than uphold their role as gatekeeper to certified sickness leave and its associated benefits (Hiscock and Ritchie, 2001; Hussey et al., 2003; Walter et al., 2012). Patients report that their anxiety increases when they sense that their doctor does not have enough time or knowledge to discuss sickness certification adequately. However, in contrast to doctors, patients report feeling that such discussions would not threaten the doctor–patient relationship (O'Brien et al., 2008).

Past research has sought to reveal the key factors that determine whether a certificate is issued. These 'factors' have tended to centre on certain behaviours, or traits, of either doctor or patient, or the patient's condition, extracted ex post facto from surveys, interviews and focus groups (e.g. Campbell and Ogden, 2006; Englund et al., 2000; Halvorsen et al., 2011; Hiscock and Ritchie, 2001; Hussey et al., 2003). The responses gained via such methods are inherently unreliable and frequently subject to social desirability biases. The omission of research examining the process of sickness certification *in vivo* has been highlighted in repeated calls within the literature for analysis which captures doctors' *and* patients' contributions during consultations (Morris and Watson, 2011; Söderberg and Alexanderson, 2003). Without such evidence, an understanding of how both participants influence each other's talk and shape the sickness certification process will never be fully realized, as the event is undeniably co-constructed, rather than an unilateral activity.

Furthermore, access to consultations data could provide an opportunity to better understand how both participants' awareness of the wider social implications of sickness certification can influence its process and outcome. For example, whether patients do make efforts to counter the possibility that they may be viewed as a malingerer and whether doctors' actions are predominantly shaped by the presenting condition and/or their responsibility to the patient, society or both.

The aim of this study was to address this current gap within the literature by providing a systematic analysis of a sample of consultations data, in order to gain evidence-based insights into how the sickness certification process is negotiated and managed by both participants. Additionally we aimed to explore possible differences between certification practices for biomedical and psychosocial problems, and between initial and repeat certificates. The reasoning behind this was due to various distinctions being made in the literature (Woivalin et al., 2004; Wrapson and Mewse, 2011) and because it was deemed important to not treat one type of condition as being more worthy of study than another. In 1977, George Engel famously warned of how medicine's long-standing, blinkered focus on physical illness was diminishing commitment to the treatment of psychosocial concerns. Today, a case can be made that this preoccupation is still relevant, through the evidenced lack of detection of mental illness within primary care (Mitchell et al., 2009). With this in mind, we took a comprehensive approach to data sampling, so that the applicability and practical value of the findings were not restricted.

## 2. Methods

### 2.1. Dataset

The study made use of an existing dataset of recordings of primary care consultations, originally collected as part of a larger study of UK general practice. Five diverse general practices were selected from two different areas of London. Each practice was paid £500 and 13 individual GPs agreed to participate. Between May 2004 and February 2005, written consent to audio-record consultations was obtained from 506 out of 1639 adult patients seen consecutively by the participating GPs. Ethical approval for the original study and an amendment for the current study was granted from Lewisham Local Research Ethics Committee.

### 2.2. Sampling strategy

Inclusion criteria were all complete consultations where the issue of sickness certification was initiated by either patients or GPs ($n = 49/506$). Consultations were included irrespective of whether or not a certificate was ultimately issued. Three main reasons for patient incapacity were identified by the research team: 'biomedical', 'psychosocial', and 'biopsychosocial'. Here we report our findings on