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General practitioners' management of the long-term sick role

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ABSTRACT

In this paper, we use qualitative research techniques to examine the role of general practitioners in the management of the long-term sickness absence. In order to uncover the perspectives of all the main agents affected by the actions of general practitioners, a case study approach focussing on one particular employment sector, the public health service, is adopted. The role of family physicians is viewed from the perspectives of health service managers, occupational health physicians, employees/patients, and general practitioners. Our argument is theoretically framed by Talcott Parsons's model of the medical contribution to the sick role, along with subsequent conceptualisations of the social role and position of physicians. Sixty one semi-structured interviews and three focus group interviews were conducted in three Health and Social Care Trusts in Northern Ireland between 2010 and 2012. There was a consensus among respondents that general practitioners put far more weight on the preferences and needs of their patients than they did on the requirements of employing organisations. This was explained by respondents in terms of the propinquity and longevity of relationships between doctors and their patients, and by the ideology of holistic care and patient advocacy that general practitioners viewed as providing the foundations of their approach to patients. The approach of general practitioners was viewed negatively by managers and occupational health physicians, and more positively by general practitioners and patients. However, there is some evidence that general practitioners would be prepared to forfeit their role as validators of sick leave. Given the imperatives of both state and capital to reduce the financial burden of long-term sickness, this preparedness puts into doubt the continued role of general practitioners as gatekeepers to legitimate long-term sickness absence.

1. Introduction

Sickness absence is a phenomenon of concern to industries and governments throughout the advanced industrial world (Evans and Walters, 2003). That said, levels of absence vary markedly across countries. Thus, Osterkamp and Röhn's (2007) analysis of sick rates across countries affiliated to the Organisation for Economic Co-operation and Development (OECD) discovered that the average number of days lost to sickness absence per employee per annum was five times greater in Poland than it was in the USA. In this paper, we wish to concentrate on Britain, the absence rates of which lay at the lower end of the spectrum, but which nevertheless are the subject of considerable governmental and commercial concern (Black, 2008; Confederation of British Industry, 2010).

While difficulties of enumeration make precise figures concerning sickness absence rates impossible, there is consensus that they are subject to a downward trend (Black and Frost, 2011; Confederation of British Industry, 2010). Yet even using the lower current estimate of 4.9 days per annum, this still involves a loss of 140 million working days, or 2.2 percent of all working time (Black and Frost 2011). In financial terms, direct costs to employers in 2010 were estimated at £16.8 billion, and indirect costs at £13.2 billion (Confederation of British Industry, 2010), with state spending on health-related benefits adding another £13 billion (Black and Frost, 2011).

Like many OECD countries, a significant proportion of the workforce (approximately 20 percent) is employed in the public sector. Absence rates in this sector are roughly 50 percent higher than in the private sector, leading to a wage cost of approximately £4.5 billion per annum. Among the reasons proffered for the higher levels of sickness absence is the more generous long-term sick pay arrangements that public sector workers tend to enjoy once they have been certified by their general practitioners (the British term for community-based primary health care physicians) as being legitimately absent (Black and Frost 2011). This frequently consists of an allowance of six months on full pay and a further six months on half pay.

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Much sickness absence taken in the UK does not require medical validation. For periods of absence of up to seven calendar days, employees are required to submit a self-certification form. However, long-term sickness absence (LTSA), usually though not exclusively defined as absence of four weeks or more (NICE 2009), invariably requires medical certification in order for employees to receive sickness benefits and maintain job security. LTSA constituted 22 percent of all working time lost to sickness in the UK in 2009 (Confederation of British Industry, 2010).

One of the most notable aspects of long-term absence is its causes. The two most common reasons for medically certified LTSA globally and throughout different sectors are musculoskeletal disorders, particularly lower back pain, and stress related ill health (Munir et al., 2008; Waddell and Burton 2005). Given that both of these complaints are frequently characterized by a heavy reliance on symptomatic presentation rather than the observation of signs, and are of an uncertain aetiology which invariably in the case of stress and frequently in the case of back pain involves psychosocial factors, diagnostic judgements are difficult and often subjective (Rhodes et al., 1999; Hussey et al., 2003McFarlane, 2007). Indeed, it is frequently the case that no specific diagnosis is given (McGee et al., 2009). These uncertainties may in turn lead to questions and doubts about the legitimacy of the complaint (Rhodes et al., 1999; Glenton, 2003).

In this paper, we examine the role of general practitioners (GPs) in the management of public sector LTSA in light of sociological debates about the social role and position of medicine. Taking Talcott Parsons's conception of the sick role as a starting point, we note how he saw physicians as playing a crucial part in the maintenance of social functioning. Subsequent analyses, while differing substantially between each other, have in common a more critical approach than Parsons to the power of the profession of medicine and its relationship with other sources of power, namely the state and capital.

1.1. Parsons, the sick role and the medical role

Parsons's analysis of the problem of sickness fits well with discourses that view sickness absence as a significant challenge to economic effectiveness. He observes that 'the problem of health is intimately involved in the functional prerequisites of the social system … so that … too low a general level of health, too high an incidence of illness is dysfunctional' (1951a: 430). Given that he regarded economic productivity as making the most significant contribution to the social good in modern capitalist societies (Parsons, 1964), we can see that contemporary anxieties about the economic costs of illness are consonant with his analysis.

Parsons was not only interested in the consequences of illness; he was also concerned with its causes. As a result, in addition to what Gerhardt (1989) terms his 'capacity model', he also developed a 'deviancy model'. This was based on his very psychoanalytic take on ill health, which led him to argue that even where a person's symptomatology appears entirely organic, there are frequently psychogenic processes at work. From this he extrapolated that motivation was a central component of illness. Even when he was challenged on this issue (Gallagher, 1976, orally presented in 1974) and forced to concede that humans are subject to pathogenic influences entirely independent of motivational factors, he retrenched with the contra-Cartesian defence 'that the interweaving of motivated and non-motivated factors at both conscious and unconscious levels is complex indeed and that any simple formula about these matters is likely to prove misleading' (Parsons, 1975: 260). The final stage of Parsons's argument was to label motivated illness as deviant because it involved the failure to fulfil expected social roles. Once again, we can see that Parsons's interpretation chimes very closely with interpretations of back pain and stress that emphasise their psychosocial aetiology and connect this with questions about the physiological legitimacy of complaints concerning them.

Parsons observed that the defence against the threat posed to society by the dysfunctional deviance of illness was to be found in the social norms that governed the appropriate roles for those who were ill. Thus, the sick role combines temporary exemption from other roles with the obligation to try to get well by seeking technically competent help. However, he feared that the sick role itself could foster dysfunctional attitudes: 'the privileges and exemptions of the sick role may become objects of a "secondary gain" which the patient is positively motivated, usually unconsciously, to secure or to retain' (1951a: 437). The motivation of people to be or stay sick requires the therapeutic process to act as a motivational counterbalance in order to restore their capacity 'to play social roles in a normal way' (Parsons, 1951b: 453). This is where he saw physicians as playing a crucial role. According to Parsons, the medical role can be seen in both individual and social terms. At an individual level, 'the role of the physician centers on his [sic] responsibility for the welfare of the patient in the sense of facilitating his recovery from illness to the best of the physician's ability' (1951a: 447). At a social level, because physicians also have the responsibility to minimize the incidence of illness, they perform 'functions of social control in the sense in which that concept is relevant to the emphasis on deviance and social control as part of the health care complex' (1975: 268). Thus, the physician 'stands at a strategic point in the general balance of forces in the society of which he [sic] is part' (1951b: 460).

1.2. Post-Parsonian analyses

Parsons's concept of the sick role was seminal for the development of the sociology of the medical profession. However, the vast majority of the work it stimulated took a contrary position. The portrayal of members of the profession as benign arbiters functioning to maintain social equilibrium cut little ice with subsequent commentators.

One form of critique involved subverting Parsons's emphasis on the significance of physicians' technical competence and prestigious training in providing the authority required for potentially deviant patients to accept their interpretations. Following Weber (1968), some commentators saw these attributes as criteria for social closure which medical professionals used to maintain their privileged social position (Johnson, 1972; Parry and Parry, 1976). From the 'professional dominance' (Freidson, 1970a) perspective, medical status was less about communal altruism and more about social advantage. In particular, the medical monopoly over diagnosis was regarded as a crucial component of its superordinate position (Freidson, 1970b).

A more moralistic critique of the professional power of medicine was provided by radical commentators such as Illich (1981) who argued that medicine's monopoly over diagnosis and treatment promoted the passive consumption of healthcare and diverted attention away from the real causes of ill health. Illich's libertarian insistence on the absolute autonomy of the individual pushed the professional dominance position to its limits (and, some might argue, its *reductio ad absurdum*).

Parsons addressed these challenges directly, arguing firstly that there was a therapeutic imperative for the superordinate status of physicians: 'with respect to the inherent functions of effective care and amelioration of conditions of illness, there must be a built-in institutionalized superiority of the professional roles, grounded in responsibility, competence, and occupational concern' (1975: 269). Secondly, he contended that the requirement for therapists to be in