Author's response to reviews

Title: Views on sick-listing practice among Swedish General Practitioners - a phenomenographic study

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Author's response to reviews: see over
Dear Editor

Thank you for sending our manuscript “Views on sick-listing practice among Swedish General Practitioners – a phenomenographic study” on review. The reviewers’ comments have been very useful and we have tried to pay due attention to all of them. Below, find a point-by-point response to each comment. Changes in accordance with the comments have been made in the manuscript.

Sincerely,

Rolf Wahlström, Malin Swartling and Stefan Peterson

Response to Reviewer Paul Gulbrandsen’s comments:

General

REVIEWER’S COMMENT: I would have liked to see some more elaboration on the limitations of the phenomenographic method.

We have developed the discussion on the limitations of phenomenographic analysis.

*Our assumption is that the description of categories or views as in our study may have a closer relationship to practice behaviour [Dall’Alba, 1998, Sandberg, 1994] than attitudes, although we cannot present any proof of such a relationship in this study. This limitation is shared with other qualitative methods.*

(Page 15, first paragraph, last two sentences.)

Major Essential

REVIEWER’S COMMENT: Add Hiscock J, Ritchie J. The role of GPs in sickness certification. London: Department of work and Pension, 2001 (Research report No 148) and Tellnes G, Sandvik L, Moum T. Inter doctor variation in sickness certification. Scan J Prim Health Care 19990;8: 45-52, and apply these references relevantly in the text.

We have added these references.

*It was shown in a British research report that differences in GPs’ perspective on their role in sickness absence management affect their involvement in their patients’ rehabilitation back to work. The ‘non interventionist’ GP characterised in that report resembles our ‘passive’ view of the responsibility of sick-listing and rehabilitation, and in several respects their ‘firm negotiator’ resembles the ‘empowering’ view in our study [Hiscock, 2001]*

(Page 13 third paragraph)

Similarly, it has been described that a widespread opinion among British GPs is that it is easy to move up and down a continuum of ‘approaches’ to sickness certification (strictly medical reasons in one end and multiple factors, including non-medical reasons in the other, and a third approach in between) and how some GPs think they have moved positions over the
course of their career, while others feel that they vary approaches depending on the situation of individual patients (Hiscock, 2001).

Consequently, in a Norwegian study, no relation could be found between GPs’ sick-listing behaviour and their attitudes (Tellnes, 1990).

Minor essential

REVIEWER'S COMMENT: I would like to see a better description (definition) of the use of the term “inclusive view”, which the authors use several times and seem to have a very clear thought about what it is themselves, while I through the paper remained unsure about this. I suggest the authors define the concept first time it is mentioned and stick to it closely in the elaboration.

Good point. We have defined the term “inclusive view”.

Such views often form a hierarchy where some views are composed of fewer aspects, compared with views higher in the hierarchy where several aspects are included (Sandberg, 2000). We have used the term ‘inclusive views’ of these more complex categories of description and have presented our results in order of such inclusiveness (Dall'Alba, 1998). (Page 6, third paragraph, eleventh sentence onwards)

REVIEWER’S COMMENT: I feel that table 2 is a bit too much of a construct unless concepts are made more distinct (“integrated”, “holistic”) The reason I say this is that in my view some of the citations in the text indicate interpretations that are not as clear cut as the authors seem to think. A table that looks so convincing as this I believe tend to overemphasise observations a bit more than I feel is warranted.

We have kept the table, but given more explanation in the table in order to make it possible to interpret without reference to the text. Regarding judging our interpretations of the different views, we need to emphasise that these interpretations do not derive from single short quotations, but from the whole interview text. It is always a challenge to find some quotes that to some extent can give an understanding of how a certain view is expressed by the interviewees. As it seems that it has caused confusion we have deleted a few quotes.

The table was created to relate the categories of responsibility to the other categories of description. This was obviously done after all categorisations were made, so there is nothing that is specifically ‘created’ to build up a convincing table. This is what we found and to some extent we believe that it supports the validity of our findings. And it is in fact a novel way of presenting relations between phenomenographic categories.

REVIEWER’S COMMENT: Examples: Citation C, page 6: “Then I feel as if they are calling” us incompetent”. In my view this is not only a view about where the commission comes from, it indicates possible different views on what physicians actually know. And in my view that is something else. Similarly in the next citation Dr T, same page, much of the citation is more about why patients seek sickness certification than about where the commission comes from.

We have removed these two quotes since they do not add to the descriptions, but rather may cause confusion. Our intention with the second part of the quote from Dr C was to show how society was perceived to be opposed to the GP and the patient, which is also part of this view. But we understand that it can be found confusing since that was definitely not the main characteristic of this view.
Discretionary Revisions

REVIEWER’S COMMENT: Page 7, Heading Conflicting… second paragraph. I found this paragraph a bit unclear. Please clarify. What do they mean by “shouldering the expert role” here?

We have changed the wording to be clearer.

One GP described trying to act only as an expert leaving the decision on benefits to be taken by social security authorities.

(REVIEWER’S COMMENT: Page 8, under heading Conflicting commissions….., second paragraph second sentence)

REVIEWER’S COMMENT: Page 8, 2a and 2b. At this point I miss references to the differences between sick-listing for clearly biomedical tasks and more psychosocial problems, which for physicians often make a difference in attitude an opinion.

Very good point. Which cases the GPs brought up is not self evident. We have added a sentence to clarify that GPs did not speak much about bio-medically clear-cut cases.

More complicated cases that included also psychosocial aspects of sickness were mostly the focus in the GPs’ reflections, while obvious biomedical cases with a clear reason for work incapability were mentioned to a much lesser extent.

(REVIEWER’S COMMENT:Page 13 Methodological considerations: Second paragraph. As evident from above, I don’t feel completely assured that these combinations observed in these informants are indications of a development of inclusive (whatever it means) views step by step. I think there is little evidence for this. Some of the doctors seem to have made changes in their practice over time but many others have not and is there any definite indication that some doctors have not started with this (preferable?) inclusive attitude?

Change of views does not happen easily, some experience that challenges our old view is required {Dahlgren, 1991}. Having a more inclusive view is preferable, since you then are supposed to have more options {Dall’Alba, 1998} in handling of sick-listing cases. The theory is not that you necessarily always move stepwise from the less inclusive view to a more inclusive one, you may so to speak start higher up in the hierarchy. However, if you have started with a least inclusive view this movement is obviously desirable. We have clarified this as below.

No GP described changes in the opposite direction.

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No GP described changes in the opposite direction.

(REVIEWER’S COMMENT: Page 8, Under the heading “Conflicting commissions…” third paragraph, last sentence)

Similarly, it has been described that a widespread opinion among British GPs is that it is easy to move up and down a continuum of ‘approaches’ to sickness certification (strictly medical reasons in one end and multiple factors, including non-medical reasons in the other, and a third approach in between) and how some GPs think they have moved positions over the course of their career, while others feel that they vary approaches depending on the situation of individual patients {Hiscock, 2001}. This may seem to be in conflict with our findings, but having a more inclusive view does not implicate that all sick-listing cases are approached taking all aspects into consideration at each occasion. Therefore, our findings do not exclude the described ‘movements’ depending on the individual patient.

(Under Discussion, page 14, second paragraph, second sentence onwards)
To become more conclusive, these aspects need more exploration as our focus was not on how views had developed over time and, therefore, other interpretations are possible.

(REVIEWER’S COMMENT: I would on the other hand consider to include a statement about a possible sex difference in the conclusion. This is an interesting observation that needs further investigation.

We have added in the conclusion a statement on the interest in exploring a possible sex difference.

The indicative sex differences in handling the conflict between patients’ and society’s interests needs further exploration. (Conclusion, second sentence)

(REVIEWER’S COMMENT: The authors might consider adding Gulbrandsen et al., Scand J Prim Health Care 2007; 25: 20-6 I have also written papers in the Journal of the Norwegian Medical Association in 2002 and 2004 about the gatekeeper role in sickness certification, these papers might also be of interest.

We have added references to Gulbrandsen 2004 and Gulbrandsen 2007 in the discussion.

Among Norwegian physicians 55% reported that they deliberately had written favourable disability pension certificates as seen from the patient's perspective at least once per year and 11% reported that they did so monthly or more often regarding sickness certification.

(Page 12, last paragraph, third sentence.)

In a more recent Norwegian survey, GPs’ relationship to sick-listing was assessed. Three groups, distinctly different from the majority of the GPs, were distinguished. Their group B, one out of two groups with a positive attitude to sick-listing for psychosocial reasons, felt burdened and permitted patients to decide to a large extent, and resembles the GPs holding the “passive” view of sickness certification in our study. GPs with this passive view described sick-listing for psychosocial reasons, but we do not know their attitude to doing so if it would be measured by the same question as in the Norwegian study.

(Page 15, second paragraph, third sentence and onwards)
Answers to comments by reviewer Lars Borgqvist

Minor Essential Revisions

REVIEWER’S COMMENT: The format of tables have to be improved.
We have made some corrections in order to harmonise the tables (fonts, headings, etc)
We have also made some notes to make table 2 more easily understandable without having to read the full text.

REVIEWER’S COMMENT: Reference 3 should be Norlund A (page 15)
We have corrected the spelling mistake in this reference.
Answers to comments by reviewer Peter Verhaak

General

REVIEWER’S COMMENT A small scale study without remarkable results.
The size of the study might seem small (19 is a low number) but it is appropriate for the method used {Bowden, 1994, Sandberg, 1994}.

REVIEWER’S COMMENT: What struck me is the gap between an apparently complicated methodology… and the very smooth results leading to a rather convincing typology.

It is a complicated methodology, but using a complicated methodology doesn’t necessarily mean that you will find something complicated. In our opinion our results reach deeper than “attitudes” which have repeatedly been shown to be in no clear accordance with peoples behaviour (added in the discussion, see quote under response to your fourth comment below). Physicians’ attitudes and behaviour in relation to sick-listing has been studied to a limited extent, but studying how physicians perceive sick-listing or their commission to sick-list has not been done before. In that respect this study does present something new.

REVIEWER’S COMMENT: I would like to have more information about the degree of agreement at several points between both authors engaged with the analysis.

Good point. We have added information about the degree of agreement between the two researchers performing the main part of the analysis.

For all domains the initial agreement was high (for 15-18 of the 19 GPs). Most often the disagreements were slight and could be resolved through further clarification of each analyst’s understanding of the statements.

(Page 6, under the heading Analysis, third paragraph, second sentence)

REVIEWER’S COMMENT: The results produce a rather descriptive account of ways of dealing with sick-listing.

It has not been our intention to produce a simple descriptive account. Yes, we use the GPs descriptions of the GPs sick-listing cases, but our attempt has been to, with the help of a phenomenographic approach, go beneath mere descriptions.

By using the phenomenographic approach we aimed at getting a deeper illumination of the GPs’ understanding of phenomena related to sick-listing, beyond stated attitudes, which have since long been known to show ambiguous relations to behaviour {Fischbein, 1975}. Consequently, in a Norwegian study, no relation could be found between GPs’ sick-listing behaviour and their attitudes {Tellnes, 1990}.

(Page 14, last paragraph)

REVIEWER’S COMMENT: I can imagine a more thorough reflection on future actions or research (e.g. a more quantitative assessment of the prevalence of different responsibilities, ways of sick-listing and existing practices, combined with a number of characteristics of GPs).

About your suggestions on future research we have similar ideas and have added a sentence about this in the conclusion.
Our findings could also be used to develop a questionnaire to measure the distribution of
different views in a wider population of GPs, which would make it possible to find
associations between views and GP characteristics.
(Page 16, Under the heading Conclusion, last sentence)

What you suggest has partly been investigated in an interesting a study published after our article was submitted, Gulbrandsen et al., Scand J Prim Health Care 2007; 25: 20-6. We have included quotes from this article, see response to Gulbrandsen’s comments.

Discretionally Revision

REVIEWER'S COMMENT: p. 4: Performing interviews by one author only “to avoid reliability problems” sound like a funny argument. Reliability is assessed by comparing the records of two individuals; by using only one interviewer the opportunity to assess reliability is taken away, reliability is not promoted. It is an ostrich attitude.

To use one, rather than several interviewers is to avoid inter-interviewer reliability problems {Goodwin, 1984}. The idea was to collect the material in a way as comparable as possible for all informants to minimise differences due to different interviewers. However, we agree that intra-interviewer problems could of course not be avoided by the approach we used. We have changed the sentence to make this distinction clearer.

Interviews were performed in November 2003 – July 2004 by the first author (MS) only, to avoid reliability problems related to using different interviewers.
(Page 5, under heading Methods, subheading Data collection, second paragraph, first sentence.)

Malin Swartling, Stefan Peterson and Rolf Wahlström, 23rd May 2007