Reviewer's report

**Title:** Sickness certification as a complex professional and collaborative activity - a qualitative study

**Version:** 2  **Date:** 11 July 2012

**Reviewer:** Wout de Boer

**Reviewer's report:**

The paper has been rewritten and gained by this.

Several points are clarified and/or updated so as to give the reader a better view of the relevance of the work.

My main concerns have not disappeared, however. I consider the following points a major compulsory revisions. Consequently I am still unable to advise about acceptance or rejection. Potentially I find it still a paper of importance in its field.

The authors describe a process in two steps (first practice sick listing, then reflect on it) that are connected in an unclear way and step two still entails many substeps that do not allow us to know how representative the data are for Swedish sick listing or how reliable the interpretations and categorisations are. The authors do not address these points at all in the discussion of limitations and I find that highly problematic. Are we to suppose that this is the factual image of the practice or is this a glimpse that allows us to understand that challenges probably need more than education? Let me illustrate:

177 MDs from Stockholm had 1380 contacts and results of these (which?) were registered and collected.

The MDs participated in a group meeting (all 177 in one group?) and compared their results to average results (how?).

This comparison led to the phrasing of challenges but we do not know how the results come into play here.

Next, the 177 participants wrote action plans that contained definition of challenge, actions to be taken, outcome measures and time tables. The outcome measures and time tables are not addressed any further but stakeholders are and these were not in the standardized action plans. So the reader is at a loss how stakeholders were defined.

One might have expected 177 action plans but it resulted in 37, containing one or more challenges. The reader is unsure if the remaining 178 are representative of all challenges.

Then group interviews take place and it takes quite some puzzling and time for the reader to suspect that this was with all (?) eight facilitators of the group meeting and the authors of the article. In the group interviews the challenge...
areas were discussed. This too is not clear to me. Are these areas the categories that are formulated? Or were the 178 challenges input in the interviews and addressed systematically?

Next, the statements about challenges were grouped, using an inductive content analysis. Reading the example of table 1 one could imagine other interpretations as well. Were different interpretations allowed or was decided for one interpretation and how was reliability established and measured?

Grouping and categorization took place, and relation to the CanMed roles, and here too the reader wonders how reliable that procedure may have been. Are the categories mutually exclusive? That seems unlikely. If not, how was the attribution decided, that leads to the quantified results of table 2? A short description of the categories would be helpful in this respect.

The determination of stakeholders and their attribution to possible actions are unclear. Was there a predefined set of stakeholders according to some theoretical approach? Was there a limitation to the number of stakeholders that could be connected to an action? We read in table 2 that there were 33 challenges about practitioner and patient interaction. There are 23 for the physician, 7 for the HCU and only 3 for the patient/employer. The combining of patient and employer into one stakeholder group seems highly problematic to me. They play different roles, have different interests and interact differently with the physicians.

These problems with the methodology need to be clarified and/or addressed as limitations of the study in the discussion section. Even with these limitations the paper contains interesting material!

In the conclusion section the stakeholders disappear nearly completely, which comes as a surprise to the reader. The physicians are required to play their competence roles in interaction with the stakeholders. Do the stakeholders not have to perform actions of their own? Is sick listing really primarily a problem of the physician?

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.