Author's response to reviews

Title: GPs' experiences of working with sick leave after changes in the Swedish social security system, a qualitative focus group study

Authors:

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Version: 3  Date: 24 September 2014

Author's response to reviews: see over
Dear Sir,

Please find enclosed our revised manuscript with the title "GPs’ experiences of working with sick leave after changes in the Swedish social security system, a qualitative focus group study".

The aim of this qualitative focus group discussion study was to describe how GPs in Sweden experience their work with sick leave. To our knowledge, this is the first qualitative study of how GPs in Sweden experience their work with sick leave after changes in the social security system. In our view, the manuscript sheds new and important light on the sick leave assignment from the GPs perspective. The study shows how teamwork with other professions as well as how new rules and regulations are helpful in this difficult task.

We would like to thank for all valid points raised by the reviewers, and appreciate the opportunity to revise our manuscript. The reviewers’ comments were very constructive and helpful in improving the clarity of our manuscript. We have tried to adequately address the criticisms outlined in the reviewer’s reports. Please find attached a document with our responses to the reviewers’ comments and the new version of our manuscript.

We further confirm that all authors fulfil the requirements for authorship. We look forward to hearing from you at your earliest convenience. Please address all correspondence to: lars.carlsson@ltdalarna.se

Yours sincerely,

Lars Carlsson
Linda Lännerström
Thorne Wallman
Inger K Holmström
Reviewer's report

Title: GPs' experiences of working with sick leave after changes in the Swedish social security system, a qualitative focus group study

Version: 2  Date: 20 July 2014

Reviewer: Wout de Boer

Reviewer's report:

1. Is the question posed by the authors well defined? Yes and no

Major Compulsory Revision required

Yes, to the extent that a measurement at a specific moment is inquired about, no to the extent that a comparison is suggested with the period before the changes in social security. This comparison should either be worked out properly or left out altogether.

*Descriptions of what it was like before the changes in the social security system are intended to provide a background and not as a comparison. We have tried to clarify this with change in the aim in abstract and background. Qualitative content analysis is also not a method suitable for comparisons.*

*Line 27: The aim of this study was to describe how GPs in Sweden experience their work with sick leave.*

*Line 91: The aim of this study was to describe how GPs in Sweden experience their work with sick leave.*

2. Are the methods appropriate and well described? No.
Major Compulsory Revision required:

I do not understand how the sampling was carried out so as to achieve maximal variation. It is unclear what variation in sampling was required beforehand and how it was determined that saturation was achieved with the 22 GPs. The authors make quite a point of their capturing of variation but the results do not indicate much variation. Focus groups with people who work together in the same location is not a way to capture differences.

With participants from the private and public health care, geographic spread in Sweden with smaller towns and bigger cities and age, gender and professional experience reflecting other primary health care centres in Sweden. When similar descriptions of the experience of sick leave assignment emerged from several FGDs we believed that saturation was reached.

3. It is unclear to me on what literature the discussion guide was constructed and the items are very global. This needs specification. What items were left out and for what reason?

We worked inductively and any for Swedish conditions appropriate discussion guide was not available in the literature. Therefore we constructed a discussion guide based on the authors’ long clinical experience, as well as the literature in the background section of the present manuscript. With open questions and responsiveness to the informants’ descriptions we don’t think that any important areas were left out.
4. One thing that changed for the GPs are the guidelines (Beslutsstöd) but they are not mentioned at all.

*Line 69: As an aid to physicians, “Guidelines for sick leave” (Försäkringsmedicinskt beslutsstöd) were introduced by the Swedish National Board of Health and Welfare in 2007, offering advice regarding reasonable sick leave time for specific diagnoses [5]. The aim was to make sick-listing quality assured and coherent, and to achieve a legally secure sick leave process.*

5. How did that selection affect the reduction to 4 categories in the analysis? The aggregation of 349 meaning units is not simply to be dismissed as with a lack of theory and emerging categories.

*Line 138: A total of 349 meaning units were identified from the five FGDs. All meaning units were included in the analysis. Further abstraction and content analysis according to Graneheim and Lundman including coding resulted in 23 subcategories as could be gathered in four categories. Analysis was made by all the authors together (Table 3) [31]*

6. Are the data sound? Unclear.

Minor essential revisions required: Given the search for variation the unanimity is surprising. I would expect an explanation for that or a more differentiated presentation of results. Moreover, it is unclear what is result of the discussions
and what is interpretation by the authors.

We have tried clarify these relevant issues with a revision of the results section.

7. Minor essential revisions required: Every now and then comparisons are made to the time before changes in social security. Half of the participants seems to have worked too short a time to have witnessed these changes, so what does this represent?

The article is about the experience of sickness assignment among GPs (today). Some have experience of working with sick leave from the time before the changes in the sickness insurance while others do not have that experience. References to the time before is meant as a background to better understand the interpretation of the informants’ responses.

8. Does the manuscript adhere to the relevant standards for reporting and data deposition?

Major Compulsory Revision required: See above: too much is left implicit.

We have attempted to answer this in the paragraphs above.

9. Are the discussion and conclusions well balanced and adequately supported by the data?
Major Compulsory Revision required: In the start of the discussion the comparison with the earlier period is addressed. The reader must infer that the changes were meant to make the work of the GPs easier. That is of course not so. And anyway the methods used do not allow a comparison over time.

*It is true that the method can’t be used for comparisons over time, but the descriptions of what it was like was meant as a background. We have tried to clarify this in the manuscript. We have also clarified that the changes were not made to make GPs work easier.*

*Line 236: The most striking finding is that Swedish GPs still perceive sick leave assignment as a burdensome task. System changes that have occurred in recent years aimed to improve and accelerate the rehabilitation of patients on sick leave have also facilitated the work with sick leave for physicians.*

10. Major Compulsory Revision required: Both conclusions are, in my opinion, not supported by the data.

*With the changes and clarifications made in the manuscript, we think that we have support for our conclusions.*

11. Are limitations of the work clearly stated?

Major Compulsory Revision required: The main limitation of the study seems to
be the unclear methods; this is not addressed.

*With the changes made in the manuscript, we think that we have clarified our methods.*

*Line 279: As the study is small-scale and qualitative, the findings cannot be generalized. With participants from the private and public health care, geographic spread with smaller towns and bigger cities and age, gender and professional experience reflecting other primary health care centres in Sweden. Similar descriptions of the experience of sick leave assignment emerged from several FGDs. This provides increased transferability and dependability. We pursued confirmability with open questions and encouraged informants to talk freely about their experiences of sick leave assignment. This gives us credibility to the results and enhances trustworthiness of this study [38]. With social security systems that differs between countries the transferability is reduced.*

12. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?

They acknowledge earlier work but do not show how they build on it.

*With the changes made in the manuscript and clarifications above we hope our work are made more comprehensible.*
8. Do the title and abstract accurately convey what has been found?
Yes.

9. Is the writing acceptable?
Yes

Level of interest: An article of limited interest

Quality of written English: Acceptable

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
Reviewer's report

Title: GPs' experiences of working with sick leave after changes in the Swedish social security system, a qualitative focus group study

Version: 2
Date: 25 August 2014
Reviewer: Mark Harris

Reviewer's report:

GP experiences or working with sick leave

This is an interesting paper on the impact of sick leave policies and requirements on GPs in Sweden.

The paper needs major revision.

1. There are numerous English grammatical problems with the paper that need to be corrected by careful editing. Examples of these in the abstract and introduction include:

   Lines 22-23; “Among general practitioners are the highest proportion of physicians who experience problems in sick leave situations” – does this mean GPs have problems taking sick leave or do you mean “GPs experience more difficulty with their demands under the sick leave policy Sweden than other physicians”

   Line 48; policies do not have intentions (governments do)

   Line 57 (‘is” – “should be”)

   Line 74-80: should this be “Physicians in primary health care centres in Sweden experience more difficulty implementing good sick leave practice than other professionals involved in rehabilitation of patients”? “Issuing sick leave has also been perceived as a health and safety problem among physicians” – this implies
that the health and safety of physicians is at risk – is this what the authors mean? If so they should describe what these health and safety problems are (eg risk of violent assault on physicians by patients).
However there are numerous others especially in the results and discussion. The paragraphs in the Discussion on page 10 are too long.

We have tried to correct all the important points referred to above.

2. In the description of the focus groups I in the methods (113-118) it should be mentioned that the FGs were conducted in Swedish (presumably) and the analysis also conducted in Swedish by the authors who are native speakers.

Line 103: All FGDs were conducted in Swedish and the analysis also conducted in Swedish by the authors who are Swedish native speakers.

3. The translation of quotes for this paper needs to be described (were these translated into English by one translator and back translated by another to check accuracy?)

Line 104: After analysis the quotes were translated to English by the authors and then checked by a native English speaking translator.
4. In the quotes in the results section there are numerous grammatical errors – are these errors in the original quote (in which case they should be left in) or are they errors in translation (in which case they should be corrected)?

*We strove to maintain linguistic errors in the original quote in the translation, as this is raw data which should not be violated.*

5. In the results the first section on physician difficulties in their professional role is well described. However the other three sections show inadequate levels of analysis.

*We have tried to deepen the description and analysis in the results section of this revised version of the article. (Line 182-233)*

6. Multidisciplinary collaboration: What activities did the collaboration other professionals involve? What aspects of care? How did communication occur? Was there a difference if these were co-located or not? Who was the coordinator of care? Did the GP have a continuing role or hand the care over to the other professional?

*This is further elaborated on line 58: The county councils have been encouraged through economic incentives from “The rehabilitation guarantee” to set up rehabilitation team with a coordinator at primary health care centres. Most often the*
rehabilitation coordinator has been a physiotherapist, psychotherapist or occupational therapist. Some rehabilitation coordinators have taken on a more prominent role to lead the rehabilitation work, while elsewhere the task is left to the treating physician. The teams are usually co-located at the primary health care centre and consists of all four professions.

7. Physician approach to patient: The conflict felt by the GPs in balancing their moral obligation to the patient and their interests and their role as an agent of government policy is well described (apart from grammar). How did the GPs respond to this conflict (apart from stress and frustration)? Where did they draw the line? How did they communicate this role conflict with patients?

Line 210: We think doubts, frustration, perceived stress and uncertainty of how to manage the patient’s problem in the best possible way also contributed to physicians’ difficulties in their professional role. How physicians communicated with the patients about their views of the problem and where the line was drawn was highly individual.

8. New sick leave policy: The new policy needs to be briefly summarised. How did the GPs interpret this? The text seems to imply that the GPs just shift the responsibility onto the Agency. Is this correct? Did the GPs describe how they communicate with the Agency? How satisfactory did the GPs find it? Did the GPs describe advocate on the patient’s behalf with the agency? Did the GPs feel a loss of power and influence under the new system? Did they discuss the
influence of the labour market on their approach – ie the ability of people to find work.

Line 154: The physicians experienced it as burdensome work to have dual roles as the patient’s physician and as an official writing sick notes to the Social Insurance Agency. These dual roles are not only exhausting to the physicians, but are most likely also confusing for patients.

Line 223: Formally The Swedish Social Insurance Agency also previously decided on sick leave to be approved or not. With new rules this became more evident. “Guidelines for sick leave” (2007), offering advice regarding reasonable sick leave time for specific diagnoses. “The rehabilitation chain” (2008) with time limits for what work tasks working capacity should be assessed against.

Line 64: An amendment to the legislation introduced in 2008 called “The rehabilitation chain” (Rehabiliteringskedjan) dictates that work ability should be assessed in relation to the patient’s regular work tasks the first 90 days of sick leave. For Days 91-180, work ability is assessed against other work tasks at the patient’s workplace. From Day 180, work ability is assessed against other normally occurring tasks on the entire labour market [4].

9. The discussion needs grammatical work. Lines 227-228 are unclear: Is the amount of sick leave being claimed or granted increasing. Line 228-230: What is the relevance and significance of the increased role of physiotherapists, psychologists and occupational therapists?
Patients are experiencing positive effects on a symptom level thanks to this multidisciplinary intervention [35]. Also, GPs appreciate the cooperation with other professionals in sick leave issues. In contrast, granted sick leave days are increasing [35].

We interpret this as the development of cooperation with other professionals like physiotherapists, psychotherapists and occupational therapists at primary health care centres in Sweden stimulated by “The rehabilitation guarantee” have been positive for physicians and patients.

10. The discussion of “various efforts” to improve the quality of care provided by Swedish GPs is inadequate – what education is provided and how do Balint groups improve the way they manage sick leave? Are there any other quality improvement or accreditation processes that are being or should be applied?

How GPs in Sweden experience their work concerning sick leave can also be affected by various efforts. Education can be a way to facilitate the handling of sick leave for GPs. In two surveys of physicians in Sweden a high proportion (up to 91%) expressed a need to develop their knowledge in insurance medicine [7, 36]. “The sick leave billion” aims to provide Sweden’s 21 county councils with financial incentives to continue their efforts to enhance the quality and efficiency of the sickness certification process includes education for physicians [2]. While Balint group discussions can give better doctor-patient relationships and higher work-related satisfaction for GPs which can facilitate the sick leave assignment [37]. The
Swedish Social Insurance Agency makes annual surveys of the percentage of approved medical certificate in accordance with specific criteria which affects the county councils compensation from “The sick leave billion” [2].

11. The discussion about validity and limitation is inadequate. This should include discussion of how representative the group was (in terms of geography, age, gender, etc). Qualitative research helps us understand the how and why rather than the frequency or extent of problems or issues.

Line 279: As the study is small-scale and qualitative, the findings cannot be generalized. With participants from the private and public health care, geographic spread with smaller towns and bigger cities and age, gender and professional experience reflecting other primary health care centres in Sweden. Similar descriptions of the experience of sick leave assignment emerged from several FGDs. This provides increased transferability and dependability. We pursued confirmability with open questions and encouraged informants to talk freely about their experiences of sick leave assignment. This gives us credibility to the results and enhances trustworthiness of this study according to Lincoln and Guba [38]. With social security systems that differs between countries the transferability is reduced although physicians and patients are comparable in various countries.

12. The ethnographic terms “emic and etic” are likely to be unfamiliar to readers and need brief explanation.
Line 287: The strength of this study is the rich material from the FGDs and researcher triangulation with different competencies, two clinically active GPs and two nurses with considerable experience working in health care centres and as well as with qualitative studies, providing both an emic (insider approach) and an etic perspective (outsider more neutral approach) on sick-listing practice.

13. It is also needs to be justified why the author consider the findings to be transferable to similar settings.

Line 279: As the study is small-scale and qualitative, the findings cannot be generalized. With participants from the private and public health care, geographic spread with smaller towns and bigger cities and age, gender and professional experience reflecting other primary health care centres in Sweden. Similar descriptions of the experience of sick leave assignment emerged from several FGDs. This provides increased transferability and dependability. We pursued confirmability with open questions and encouraged informants to talk freely about their experiences of sick leave assignment. This gives us credibility to the results and enhances trustworthiness of this study according to Lincoln and Guba [38]. With social security systems that differs between countries the transferability is reduced although physicians and patients are comparable in various countries.