Scandinavian Journal of Primary Health Care

ISSN: 0281-3432 (Print) 1502-7724 (Online) Journal homepage: http://www.tandfonline.com/loi/ipri20

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To cite this article: Aase Aamland & Silje Maeland (2018) Sick-listed workers' expectations about and experiences with independent medical evaluation: a qualitative interview study from Norway, Scandinavian Journal of Primary Health Care, 36:2, 134-141, DOI: 10.1080/02813432.2018.1459168

To link to this article: https://doi.org/10.1080/02813432.2018.1459168

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Published online: 12 Apr 2018.

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SCANDINAVIAN JOURNAL OF PRIMARY HEALTH CARE
2018, VOL. 36, NO. 2, 134–141
https://doi.org/10.1080/02813432.2018.1459168

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RESEARCH ARTICLE

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Sick-listed workers' expectations about and experiences with independent medical evaluation: a qualitative interview study from Norway

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ABSTRACT

Purpose: To reduce the country's sick leave rate, Norwegian politicians have suggested independent medical evaluations (IMEs) for sick-listed workers. IME was tested in a large, randomized controlled trial in one Norwegian county (Evaluation of IME in Norway, or 'the NIME trial'). The current study's aim was to explore sick-listed workers' expectations about and experiences with participating in an IME.

Material and methods: Nine individual semi-structured telephone interviews were conducted. Our convenience sample included six women and three men, aged 35–59 years, who had diverse medical reasons for being on sick leave. Systematic text condensation was used for analysis.

Results: The participants questioned both the IME purpose and timing, but felt a moral obligation to participate. Inadequate information provided by their general practitioner (GP) to the IME doctor was considered burdensome by several participants. However, most participants appreciated the IME as a positive discussion, even if they did not feel it had any impact on their follow-up or return-to-work process.

Conclusions: According to the sick-listed workers the IMEs were administered too late and disturbed already initiated treatment processes and return to work efforts. Still, the consultation with the IME doctor was rated as a positive encounter, contrary to their expectations. Our results diverge from findings in other countries where experiences with IME consultations have been reported as predominantly negative. These findings, along with additional, upcoming evaluations, will serve as a basis for the Norwegian government's decision about whether to implement IMEs on a regular basis.

ARTICLE HISTORY
Received 4 July 2017
Accepted 8 December 2017

KEYWORDS
General practice; sick leave; independent medical evaluation; workers' compensation; qualitative research

KEY POINTS

Independent medical evaluations for sick-listed workers has been tested out in a large Norwegian RCT and will be evaluated through qualitative interviews with participating stakeholders and by assessing the effects on RTW and costs/benefits. In this study, we explored sick-listed workers' expectations about and experiences with participating in an IME.

- Participants questioned both the IME purpose and timing, but felt a moral obligation to participate.
- Inadequate information provided by their general practitioner (GP) to the IME doctor was considered burdensome by several participants
- Sick-listed workers appreciated the IME as a positive discussion, even if they did not feel it had any impact on their follow-up or return-to-work process.

Introduction

Norway has been identified as having among the highest rates of sick leave in Europe [1]. Norwegian general practitioners (GPs) are important stakeholders because they manage 80% of individuals on long-term sick leave [2]. The GP has a legal role, being responsible for certifying and documenting the impact of the illness on work ability. The GP is also required to determine treatment needs and arrange appropriate referrals. They are expected to cooperate with employers and the public welfare agency (the Norwegian Labour and Welfare Administration; NAV), initiating

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different treatments and public welfare agency measures to promote return to work (RTW). The GP's dual role as patient advocate and society's most important gatekeeper has often been seen as a problem; i.e. the GP's objectivity in assessing illness and disease has been questioned along with its impact on patients' work capacity [3]. Several studies have described how GPs avoid conflict to preserve good alliances with their patients, but leave their patients to control the sickness absence process [4–7]. This has led Norwegian politicians to suggest implementation of independent medical evaluations (IMEs), in which an independent doctor intervenes six months into the sickness episode and hence potentially interferes with the relationship between the sick-listed worker and their GP. Both public and private insurance systems in different jurisdictions commonly use IMEs to determine the functional capacities of workers who claim inability to work due to illness or injury [8,9]. However, instead of simply implementing IMEs, the Norwegian government initiated a large, randomized controlled trial in one representative county constituting 10% of Norway's population, in order to provide evidence on the effects of IME on RTW after long-term sickness absence. In this trial, called the Effect of Evaluation of IME in Norway (NIME trial), all workers sick-listed for six months were assessed for eligibility, randomized and summoned by the public welfare agency for an IME [10]. As this was a trial, sick-listed workers randomized to IMEs did not risk any sanctions if they did not attend.

IME doctors were specially trained GPs who were familiar with the complexity of general practice and employed by NAV during the NIME trial. A case report was requested from the treating GP by the IME-doctor in preparation for the consultation. The main purpose of the IME was to provide a new perspective on the sickness absence episode, identify RTW resources, explore workers' expectations and perceived barriers to RTW, and make suggestions for further follow-up and level of sickness absence [10]. These are important aspects to explore because the IME doctors' decision may potentially be highly influential, determining the ability to access medical services, lodge legal claims and receiving wage-compensation benefits or not [11]. Studies in other countries have described IMEs as unethical, superficial, physically, and emotionally painful and stressful, leading to increased pain, emotional stress, and symptom flare-up [12–14]. Sick-listed workers have also noted differences in medical opinion between insurer-employed medical assessors and their own treating practitioners [13], potentially causing uncertainty about whom to trust [14].

The NIME trial is the first randomized controlled evaluation of IME worldwide and will have a broad analytical approach including qualitative interviews with participating stakeholders and analysis of costs/benefits in addition to effect. In this study, we explored sick-listed workers' expectations about and experiences with participating in an IME.

Material and methods

Recruitment and sample

The project secretary identified a purposive sample of eight sick-listed workers and sent out invitations by personal letters; however, none responded even after a reminder letter. We then changed our strategy and encouraged three of the in total nine IME doctors to help with recruitment. After their IME consultations were finished, they asked some of the sick-listed workers if they would be interested in participating in an interview study as part of the evaluation of the trial in which they were enrolled. Those who responded positively received an informational letter about the interview study. A.A. called these potential participants to provide additional information, confirm their participation, and settle a date and time for the interview. The final data were drawn from nine individual semi-structured telephone interviews. Our convenience sample of participants was comprised of six women and three men aged 35–59 years. Six participants had higher education (defined as higher than a college degree) and worked both in the public and the private sector. Their reasons for sick leave were diverse and included different psychological distress such as anxiety, sleep disorder and depression, medically unexplained symptoms such as chronic fatigue, irritable bowel syndrome and whiplash, and different somatic diseases such as arthritis and lymphedema. The participants had been listed with their current GP for a median of eight years and all had a six-month median duration of their sickness absence.

Data collection

We developed an interview guide in co-operation with the trial's user representative, which included both type and order of questions, to ensure a non-threatening introduction to, and tone during, the telephone interviews. The interview guide was used during the interviews more as a structural outline than a compulsive checklist [15,16]. A.A. conducted the interviews, each of which lasted 30 minutes or less, to reduce the chance of participant fatigue [17]. Prior to each

interview, the participant was encouraged to reflect upon their expectations about, and concrete experiences with participating in an IME consultation. This was emphasized in both the invitation letter and during personal contact with A.A. The interviews were audiotaped and transcribed verbatim. Assessment of information power guided the sample size with consideration paid to the study aim, sample specificity, use of established theory, quality of dialogue, and analysis strategy [18]. During the process, A.A. read the first three transcripts and took special care to follow new topics that came up during the next interviews, which further enhanced the variety of participants' expectations and experiences. Our study had a narrow aim and we managed to recruit a varied participant sample with abundant experiences, which allowed us to answer our research question. Our study was not supported by an established theory, but we found that seven of the nine interviews had a high dialogue-quality with strong and clear communication between the researcher and the participant, and a thematic cross-case analysis method (see below) was applied. Hence, after nine interviews, we evaluated the information power [18] to be sufficient to perform analyses.

Analysis

We used systematic text condensation, which is a thematic cross-case analysis method [19]. The method comprises four steps: (i) reading all material to obtain an overall impression and recognize preliminary themes; (ii) develop code groups from preliminary themes, identify meaning units reflecting different aspects of participants' expectations and experiences, and coding for these; (iii) establish subgroups within each code group exemplifying vital aspects of each code group, condense the contents of each of them, and identify illustrative quotations for each subgroup; and finally (iv) synthesize the condensates from each code group, presenting a reconceptualised description of each category concerning different kinds of expectations and experiences from having participated in an IME. Both researchers equally took part in all analytical steps of STC. Striving for reflexivity, we both wrote and shared our preconceptions (what we thought we would find) before starting the interviews. In this way, it is less likely to mix the results which we actual found with what we thought we would find [16]. During the analytical process, we looked through our written preconceptions and actively sought information in the transcripts which contradicted our preconceptions.

Results

Predominantly negative expectations, but feeling a moral obligation to show up

Many negative reactions were evoked when the participants were summoned to undergo an IME. Several participants described how they felt frustrated, primarily because they had to see yet another health professional. Some felt considerable uncertainty about seeing a new health professional and revealing private and emotionally difficult reasons for their on-going sick leave. A few asked themselves if their diagnoses were to be placed under scrutiny and found this strange because they viewed their condition as medically clear. Some participants described how they initially experienced spontaneous negative feelings, but then started thinking about the reason for an IME. A few participants saw the IME as a threat; i.e. a measure of control by NAV. They were scared to be forced to go back to work against their will and their GP's advice, and feared that the IME doctor would question if they were legitimately receiving sickness benefits. When discussing their fears with their GPs some GPs had told our participants that the IME may be seen more as a control of GPs rather than a control of sick-listed workers. They reminded themselves that their GP had issued the sickness note, they had not just called in sick themselves. This changed their focus from the IME controlling them as legitimate benefit receivers to being in control of their GPs. However, a few participants were surprised that the system did not seem to have confidence in their GP's assessments. One female participant working as a pharmacist, who was struggling with long-lasting grief, described her reaction when reading the invitation letter:

> *The reaction I got when I opened the letter.... First, I found it galling and it left me exhausted. Then I got angry and thought, "OK, now I have to relate to yet another professional, although I have my GP and my psychologist who already do the follow-up. (Olivia)*

Several participants described feeling obliged to show up for moral reasons. First, they did not want to be perceived as being difficult. Second, because they were sick-listed, they had plenty of time to attend the appointment. Furthermore, some participants thought that an IME could potentially serve as a positive second opinion since health professionals may assess clinical situations quite differently. One female participant working as a teacher who was on graded sick leave due to depression, described her ambivalence about seeing the IME doctor:

Well, I see the two sides of the project … it is a way to make sure that the system works, but also to ensure that we as patients get a proper follow-up relevant to our reason for being sick-listed. (Rosie)

Not really that different, but a resume from the GP would have helped

Some participants had the experience that their GP had not sent their medical records explaining why they were sick-listed to the IME doctor. Thus, they had to describe their situation from its origin, which could be both time-consuming and emotionally difficult. A few participants expressed strong opinions that the medical records from the GP were crucial and felt the need to confront their GP about this at their next visit. Still, other participants emphasized a need to tell their own story to complement a short summary of their medical records from their GP. One female participant who was sick-listed due to lymphedema considered it was easier for her to describe the reason for her on going sick leave compared to people with psychosocial distress or medically unexplained symptoms, but she still found it challenging that her medical records had not been sent from her GP to the IME doctor in advance:

It was a shame that he (the GP) had not been able to send the records as he had been asked to do. As a result, we spent more time on my history when she (the IME doctor) could instead have been prepared prior to the consultation. (Leslie)

Some participants said they had plenty of time with the IME doctor, and far more time than with their GP. Yet other participants felt that their GP also gave them plenty of time, sometimes through double sessions; therefore, they reported similar experiences with both. Many participants reflected on how the IME doctor had a different style than their GP, that it was like an interview, a survey, or an interrogation with more superficial or impersonal questions. A few participants had expected some form of clinical examination. One male participant with arthritis described how he had expected the IME doctor to examine his joints. Furthermore, a few participants felt that it would have been more appropriate if their GP had been there to elaborate on and justify their medical advice. They felt they had no other option but to report the advice their GP had given them. One female participant in her fifties working as a secretary and struggling with whiplash symptoms, compared the length of the consultations with the IME doctor and her GP:

Yes, it probably lasted a bit longer, the IME doctor had things to fill in, but really, I speak quite a lot to my GP too … so, there was not a lot of difference in the time spent. (Kate)

An affirmative talk, which did not lead to any change

Several participants described a feeling of relief after the IME consultation and stated that their fears had been unnecessary. Many participants experienced the IME doctor as a nice doctor who was easy to communicate with, and who saw them as a person. There were several stories about how the IME doctors were of the same opinion about prior assessments and previously planned follow-up strategies, which lead to feelings of reassurance. Examples of supportive feedback included ‘you don’t seem to be the type who shirks your duties at work’ and ‘it’s great that you work fifty per cent of full-time despite your ongoing distress’. A few participants felt it could potentially strengthen their case with their employer if the IME doctor confirmed their need for sickness absence. Several participants said that not all IME doctors could possibly be as nice as the one they had met and concluded that they must have been lucky. One female participant described her positive experience with being supported by the IME doctor:

The other doctor said, how should I say it? She was very like this, “the treatment you receive is good for you, keep going like this” … She was really expressing recognition. (Leslie)

Not all participants had received their IME report by the time of the interview, but those who had said it provided an overall correct assessment of their situation. However, most of the participants concluded that the IME consultation had not resulted in any new ideas or suggestions for further management. Some of the IME doctors had indeed suggested some kind of action and/or treatment, but it was often something the participants had tried already. Therefore, several participants questioned the timing of the IME and expressed that it should have been initiated earlier. However, one female participant reported that the IME doctor had suggested in-patient work-related rehabilitation, which she had not heard about before. Nevertheless, many of the participants appreciated that the IME doctor said many wise and well-chosen words, which they kept in mind. In a way, the information from their GP and the IME doctor was complementary, but they had used different words and explanations for the sick-listed workers’ ongoing distress and plans for recovery. Despite this, many participants concluded that the IME consultations had not been necessary for them, but felt quite

sure that it could be necessary for others whose situation was less complex. In justifying this, they referred to their clarified diagnoses and/or unique situation, which was more complex than, e.g. 'a broken knee that could be fixed'. An IT consultant in his forties struggling with fatigue and sleep disorder, summed up his experience with the IME consultation:

> *To be quite honest, it did not result in anything at all – except that it was a nice talk. (Mike)*

Discussion

Summary

The participants questioned both the purpose and the timing of the IME, but felt a moral obligation to participate. Lack of medical record information from GPs was burdensome for several of the participants. However, most participants appreciated the IME as an affirmative talk, even if they did not feel that it led to any change in their follow-up and/or RTW process. Below, we discuss the strengths and limitations of the study design and the impact of these findings.

Methodological considerations

Concerning the sampling of participants, we had to shift our strategy from an intended purposive to a convenience sample. This resulted in more women than men in our sample (we intended a 50/50 distribution when we sent out the initial invitation letters). Otherwise, we retained diversity with respect to age, reason for sick leave and level of education. Because IME doctors helped us with recruitment, this may have led to the inclusion of sick-listed workers who had more positive attitudes about both the IME doctors and the IME itself. We expect that it was easier for the IME doctors to mention the study to sick-listed workers with whom they had had a good, friendly dialogue. This concern was partly confirmed, as most of the participants feared the IME when they were summoned, but expressed that they had positive experiences with the IME consultation itself. Still, some also expressed having had some negative experiences, which to some degree balanced our concern about information power. However, this sampling procedure may have given us limited input from the most fragile and marginalized sick-listed workers summoned to undergo IME. Nevertheless, this would also occur with other recruitment strategies because these individuals are unlikely to volunteer for this type of study due to their vulnerability. This may indeed have been one of the reasons why the eight sick-listed workers who were initially invited to participate never replied to our invitation. Furthermore, we have not gained any insight into the expectations about IMEs among sick-listed workers who were summoned but did not undergo the IMEs because it was not mandatory. Our recruitment challenges obviously have consequences for the transferability of our findings. A possible way to reach more vulnerable sick-listed workers could be to ask GPs to nominate patients for an IME whom they consider especially vulnerable.

In qualitative research, face-to-face interviews are used more often than telephone interviews [20]. However, it is well documented that telephone interviews have some advantages, such as decreased costs and travel, more anonymity and privacy, and potentially more balanced distribution of power between interviewer and interviewee [20,21]. Telephone interviews may also provide equally rich, vivid, detailed, and high-quality data compared to face-to-face interviews, despite the loss of visual and non-verbal cues [20,21]. Furthermore, neither information about contextual data and facial expressions, nor body language have been used extensively because our method of analysis was based on the transcripts. The interviewer (A.A.) is an experienced GP and thus accustomed to patient-centred communication. As supported by the literature on successful telephone interview strategies, A.A. used conversational pauses, chose words and annotation to respond empathetically and non-judgementally, reframed questions, used probes and prompts, and communicated her presence to the interviewees with careful use of acknowledgment tokens such as 'right' and 'yeah'. Altogether, this created a non-threatening atmosphere in which the participants could articulate their experiences and may have strengthened the internal validity of our study. However, an interviewer with a different professional background might have encouraged the participants to report other types of experiences [22].

We did consider different study designs. An Internet-based approach might have reached more sick-listed workers, but in that case, we would have lost the opportunity to validate their reports as A.A did during the telephone- interviews. A face-to-face interview would have been more time-consuming, costly, and have required more travel to reach the geographically dispersed and functionally disabled sick-listed workers.

What is known from before – what does this study add?

IMEs is a new initiative trialled in one representative Norwegian county. This may explain why several

participants felt uncertain about the purpose of the IME. In other countries, IMEs are regularly performed and mandatory, with potential loss of financial support if unattended [14,23]. Loss of income was not a threat for our participants because the right to sickness absence benefits is a legal right in Norway [24]. Still, our findings elucidate that participants did not want to attend the IME, but felt a moral obligation to show up. This resembles previous findings from participants who want to be viewed as honest and hardworking, and not as making false claims [25].

Previous IME studies in other contexts have described sick-listed workers' experiences with IME doctors who were rude and disrespectful, and their independence has been questioned [14]. Our findings diverged from these findings because these participants consistently described the IME doctors as polite, having a genuine interest in the participants' reasons for sick leave, being affirmative, and nice to communicate with. This may be explained by the fact that the Norwegian IME doctors were GPs in their daily practice, which means they are used to examining and managing similar cases. This contrasts with other IME contexts in which, e.g. an orthopaedic surgeon may work as an IME doctor assessing workers' mental health problems and the influence of these on their work capacity [14,25]. A systematic review has shown that physicians' verbal behaviours, including patient-centred behaviour, empathy, reassurance, support, and positive reinforcement of patient actions were linked to patient satisfaction, compliance, comprehension, and perception of a good interpersonal relationship [26]. Based on our findings, it may be that the IME doctors accomplished some of these verbal behaviours and may support the use of trained GPs as IME doctors.

Furthermore, the participants in our study received a copy of their IME report, which is not the case in some systems where workers have to request a copy of the report from the insurer to gain insight [27]. Some have suggested that an IME does not play a therapeutic role in the recovery process [28]. Our data do not provide insight into whether the IME report served a therapeutic role; however, this transparency may counteract a possible uncertainty among sick-listed workers. In addition, and opposed to other IME contexts, the IME doctors could not overrule the treating GPs' assessments or change the sickness absence benefits. These factors may explain our finding of an overall satisfaction with the Norwegian IMEs to some extent, in contrast with other IME studies in different jurisdictions [12,14].

However, this overall satisfaction does seem surprising as the participants spent considerable time and effort to attend the IME and still did not report that they got anything out of the encounter (e.g. new insight, new treatment options). This is consistent with findings from other studies showing that if patients' expectations about being met with empathy and respect are fulfilled [29], they may feel positive about the encounter regardless of the outcome [30]. Other studies have described an iatrogenic harm to vulnerable sick-listed workers after IMEs [13,31], which was not supported by our findings. However, we speculate that the affirmative IME consultations may have led to consolidation of the participants' sick role. This issue will be addressed in the effect evaluation.

Finally, some participants expected a clinical examination, which was not part of the IME doctor's assignment. An extensive literature shows that health professionals must consider the biological, psychological, and social factors that influence a person's health in the occupational setting [32]. Consequently, this was the model in which the IME trial doctors were trained. Still, the lack of clinical examinations our participants wanted may support the need for an IME with a more functional focus. This has been suggested by Clifton who called for a 'functional IME' [33] and by Bachmann et al. in their protocol for a structured functional evaluation process for IMEs of claimants presenting with disabling mental illness [11].

Conclusion

Our results, based on sick-listed workers' expectations about and experience with IMEs, show that IMEs are administered too late and disturb already-initiated efforts and treatment processes rather than facilitate them. Being summoned to an IME evoked negative feelings, uncertainty, and fear of not being a legitimate benefit receiver. However, the participants' overall impression was that the consultation itself was a nice, affirmative discussion that confirmed they were on the right track in terms of recovery and RTW. These findings, together with findings from further up-coming evaluations, will serve as a basis for the Norwegian government's decision about whether to implement IMEs throughout Norway.

Acknowledgments

We are in debt to the participants who were willing to share their time and insights. We also thank the IME doctors who facilitated participant recruitment.

Ethics approval and consent to participate

All participants signed a declaration of informed consent. The Regional Committee for Ethics in Medical Research assessed the study to be outside their mandate (2015/506). The Norwegian Social Science Data Services approved the study (45866/3/KS). The work was carried out in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki).

Disclosure statement

Both authors declare that they have no conflict of interest.

Funding

Norwegian Labour and Welfare Administration

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