Return to work with chronic pain: employers’ and employees’ views

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Background
The sickness certification and return to work (RTW) of people with chronic pain are important health and economic issues for employees, employers, taxpayers and the UK government. The ‘fit note’ and a national educational programme promoting RTW were introduced in 2010 to curb rising rates of sickness absence.

Aims
To investigate employers’ and employees’ experiences of managing RTW when someone has taken sick leave for chronic pain and to explore the perceived efficacy of the fit note.

Methods
A qualitative study, comprising semi-structured interviews with employers who had managed sick leave cases and employees who had experienced sick leave for chronic pain. Interviews were recorded, transcribed and the data analysed using constructivist grounded theory principles.

Results
Five themes were elicited. Firstly, frequent enquiry after health status was seen as intrusive by some employees but part of good practice by employers and acknowledging this difference was useful. Secondly, being able to trust employees due to their performance track record was helpful for employers when dealing with complex chronic pain conditions. Thirdly, feeling valued increased employees’ motivation to RTW. Fourthly, guidelines about maintaining contact with absent employees were useful if used flexibly. Finally, both parties valued the fit note for its positive language, interrogative format and biomedical authority.

Conclusions
The fit note was perceived to be helpful if used in combination with other strategies for managing sick leave and RTW for people with chronic pain. These strategies may be applicable to other fluctuating, long-term conditions with medically unexplained elements.

Key words
Chronic pain; employer–employee relationship; fit note; fitness for work; return to work; sickness absence.

Introduction
There is good evidence that ‘safe and accommodating’ work is beneficial for health and well-being [1]. Sickness absence is a major issue in the UK, because sick leave rates have risen sharply since 1970, costing an estimated £100 billion per annum [2]. (‘Sickness absence’ or ‘sick leave’ may be referred to as ‘absence attributed to sickness’ as the former terms imply that sickness is the cause for absence whereas it might not be. Here, we use ‘sick leave’ for brevity and because participants stated their absence was due to ill-health.)

In the UK, employees can self-certify for up to 7 days, after which sick leave must be validated, usually by a primary care practitioner (general practitioner (GP) in the UK). Minor mental health disorders followed by musculoskeletal problems are the most common grounds for sick leave [3]. Chronic pain is often musculoskeletal in origin and has negative psychological effects, making sufferers a useful exemplar for the purposes of our study. Whilst sick leave can be entirely appropriate to allow recuperation, if not carefully managed, it can extend the sick role unnecessarily, increasing incapacity [4].

The UK government has responded to the socioeconomic costs of sick leave with several policy interventions, including a national education programme for GPs, patients, occupational health (OH) professionals, employers (especially, line managers and human
resource personnel) and employees. This programme
summarizes the evidence that work promotes healthy
outcomes for most individuals and describes negotiation
strategies to change how stakeholders conceptualize ill-
health and how work may be adapted to suit, e.g. via
flexible working time [5]. The ‘fit note’ (strictly a state-
ment of fitness for work) was introduced in April 2010,
originally in a paper format, now being replaced by an
electronic version [6]. This statement focuses on what
people can do, rather than what they cannot, aiming to
return more employees to work via temporarily limited
or revised duties. GPs can still declare patients unfit for
work, but the alternative classification of ‘fit for work’
now states patients ‘may be fit for work taking account
of the following advice’. There are four advice options:
phased return, altered hours, amended duties and work-
place adaptations.

The research reported here follows an earlier study
of doctors’ and patients’ views of the sickness certifica-
tion consultation; doctors’ views on the fit note have
been published elsewhere [7]. This research suggested
that employers play a significant role in managing sick
leave and return to work (RTW), warranting further
enquiry into the process. We conducted a qualita-
tive study with employers and employees about for-
mal RTW conversations, following Cohen et al. [8],
and also researched wider processes, such as keeping
in contact with employees on sick leave and manag-
ing daily interactions once they were back. We also
asked for participants’ views on the fit note in RTW
processes.

Qualitative research enables in-depth explorations
of experience and was judged suitable for this study of
stakeholders’ views of RTW.

Methods

Semi-structured interviews were conducted with 13
employers and 13 employees. We recruited by two meth-
ods: firstly, from meetings between our university and
businesses, designed to encourage research collabora-
tion on research into work, health and well-being as part
of university/business ‘Knowledge Escalator’ initiatives.
Secondly, we placed advertisements on the websites of
four pain charities and one chamber of commerce. Ten
participants in each group (employers and employees)
were unknown to each other; there were three line man-
ger/employee pairs. Each participant was interviewed
separately, but pairs knew that interviews would dis-
cuss the same case of sick leave. This made it especially
important to anonymize data, and we have therefore
removed or changed identifying features (see Tables 1
and 2).

Participants had to be at least 18 years old and able
to provide informed consent, and they were screened
by telephone or email to ensure they met the inclusion
criteria. Employees had to be in employment and have
needed a sick or fit note within the last year, or be on
current sick leave; to have consulted their GP in the last
year; to have experienced pain lasting over 3 months
within the last year and to consider chronic pain to be
the major reason for sickness absence. Employers had
to have some experience of managing sick leave for an
employee with chronic pain. This was assessed simply
by asking them on the participant information sheet if
they had such experience. We wanted to study individual
managers’ views, not those of corporate spokespeople.
Our wide inclusion criteria meant we recruited some
senior managers who were responsible for most people
within a company. However, our inclusion criteria
clearly stated that all managers had to have direct expe-
rience of line-managing sick leave for an employee with
chronic pain.

Participants were sent information packs at least a
week before interview. Participant queries were reviewed
and informed consent was obtained. Saturation sam-
ping was used, in which interviews are conducted until
no new themes emerge from sequential data analysis
[9]. Saturation often occurs at 12 interviews [10], the
reason for our choice of a sample size of 13 subjects
per group.

Interviews were conducted from January to April
2011. Three employers chose to be interviewed in per-
son, and ten by telephone. Two employees were inter-
viewed in person and 11 by telephone. Two employers
withdrew citing lack of time after consenting, but no
employees did so.

The interview schedule covered views on sickness
absence and RTW for chronic pain patients, includ-
ing the fit note. Interviews were audio-recorded, tran-
scribed and coded. Constructivist grounded theory
principles were used to analyse the data. This process
approaches the research by proceeding with interviews
and data collection in the absence of a priori theoreti-
cal models or intention to test-formulated hypotheses.
Major tenets are that (i) individuals’ realities have cat-
egories which we can comprehend and broadly group;
(ii) the research, as a social situation, will generate
as well as collect data; and (iii) as investigators we
can only offer an interpretation of the resultant data
[11]. Grounded theory uses coding activities to ana-
lyse data; a code is simply a conceptual label applied
to one or a set of phenomena indicated by the data.
Initial codes are closely examined to discern those that
serve to make the data most coherent; these become
focused codes, essentially thematic headings [9]. Here,
one researcher produced prospective codes, displayed
with verbatim quotations. Codes were investigated and
arranged into analytical hierarchies, until core catego-
ries were ascertained. A second researcher took a pro-
portion of the quotations and categorized them into
the previously identified core concepts. Variations in
interpretation were discussed until broad consensus among the research team was established. NVivo 9 software was used to organize the analysis. We recorded participants’ characteristics that literature reviews suggested might be salient such as company size [12]. We did not analyse these data quantitatively as in this study, we were interested in whether participants spontaneously discussed the role of characteristics (such as time in a particular job) in relation to sickness absence. Aggregated data are presented below. Ethical approval was given by our university’s Research Ethics Approval Committee for Health.

Table 1. Summary data of recruited employees’ and employers’ characteristics (n = 26)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Employees</th>
<th>Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>F = 5; M = 8</td>
<td>F = 4; M = 9</td>
</tr>
<tr>
<td>Part of a pair?</td>
<td>3 yes; 10 no</td>
<td>3 yes; 10 no</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Schools: 3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>IT: 2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Universities: 1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>National Health Services: 2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Airline: 1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Army: 1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Insurance: 1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other: 2</td>
<td>4</td>
</tr>
<tr>
<td>Size of organization</td>
<td>1–9 micro (Mc): 0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>10–49 small (S): 1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>50–249 medium (M): 1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>250+ large (L): 11</td>
<td>7</td>
</tr>
<tr>
<td>Profession or job title</td>
<td>Teacher (2)</td>
<td>Human resource manager (3)</td>
</tr>
<tr>
<td></td>
<td>Academic (1)</td>
<td>Line manager (10)</td>
</tr>
<tr>
<td></td>
<td>Administrator (1)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Behaviour support assistant (1)</td>
<td>–</td>
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<tr>
<td></td>
<td>Contract manager (1)</td>
<td>–</td>
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<tr>
<td></td>
<td>Executive officer (1)</td>
<td>–</td>
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<tr>
<td></td>
<td>Major (1)</td>
<td>–</td>
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<tr>
<td></td>
<td>Manager (1)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Nurse (1)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Personal assistant (1)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Software developer and engineer (1)</td>
<td>–</td>
</tr>
<tr>
<td>Years worked for organization (employees) or</td>
<td>Mean (normally distributed data): 13.9</td>
<td>Mean (normally distributed data): 7.7</td>
</tr>
<tr>
<td>years in role (employers)</td>
<td>Range: 3–31</td>
<td>Range: 2–15</td>
</tr>
<tr>
<td>No. in team (employees) or no. people managed</td>
<td>Median (not normally distributed data): 6</td>
<td>Median (not normally distributed data): 9</td>
</tr>
<tr>
<td>employers; either as direct line manager or</td>
<td>Range: 2–48</td>
<td>Range: 4–2,587</td>
</tr>
<tr>
<td>senior manager responsible for a large section</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>of the company</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Works full-time (FT); part-time (PT); on sick</td>
<td>FT:9; PT:2; SL:2</td>
<td>–</td>
</tr>
<tr>
<td>leave (SL) (employees only)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Years with pain (employees only)</td>
<td>Median: 4 (range 0.75–15)</td>
<td>–</td>
</tr>
<tr>
<td>Chronic pain condition (employees only; some</td>
<td>Fibromyalgia (5)</td>
<td>–</td>
</tr>
<tr>
<td>participants had multiple morbidities)</td>
<td>Back (4)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Joint hyper mobility syndrome (2)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Osteoarthritis (2)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Sciatica (2)</td>
<td>–</td>
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<tr>
<td></td>
<td>Neck (2)</td>
<td>–</td>
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<tr>
<td></td>
<td>Hip (1)</td>
<td>–</td>
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<tr>
<td></td>
<td>Knee (1)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Spine (1)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed general (1)</td>
<td>–</td>
</tr>
<tr>
<td>Recruited by Knowledge Escalator event (KE) or</td>
<td>KE = 7 or I = 6</td>
<td>KE = 10 or I = 3</td>
</tr>
<tr>
<td>internet (I)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Telephone (T) or face-to-face (F) interview</td>
<td>T = 11 or F = 2</td>
<td>T = 10 or F = 3</td>
</tr>
</tbody>
</table>
I think psychologically it makes a difference, because you feel like you're getting somewhere. I mean, with the old sick note, it's partly adjusting his hours but also making sure that if he felt he couldn't do two hours, if after one hour 40 minutes he said "I've got a different chair … and I don't have to twist and turn at all …

I believe the well note was valued, but again, knowing that it was alright to ask for help was symbolically important. Both parties reported this eased previous tension around their verbal exchanges. The second theme was that managers used holistic knowledge of employees to assess the authenticity of illness claims. Employers referenced employees' track records to decide how much to trust people's accounts of often subjective conditions like pain (quotation 1).

The third theme mirrored employers' reports of the value of trust, as employees stated that physical adjustments to workstations, flexi-time and sometimes taxis to work were important in enabling them to work, not just practically but also as symbolic gestures of trust and value (quotation 3). Physical support from colleagues was valued, but again, knowing that it was alright to ask for help was symbolically important.

The fourth theme was that both parties reported being flexible with procedures was useful. One employee discussed how he encouraged his supervisor to telephone with work queries, although the supervisor was initially unsure (quotation 4). When discussing these calls, employee 9's supervisor reported feeling some unease but found it very helpful from a business perspective and also because he knew they reassured his employee. This employer also realized over time the value of his employee contributing when less than 100% fit.

The fifth theme was that both parties were positive the fit note would assist behaviour change. Employers focused on its positive language and liked the fit note's format, which they thought encourages conversation between stakeholders (quotation 5).

Employees also liked the fit note. Several discussed in detail how its format, relative to the old sick note, had benefited RTW negotiations. Firstly, this was because being considered in terms of fitness not sickness was beneficial to how participants saw their capacity (quotation 6). Secondly, the fit note summarized more detailed conversations between employees and GPs, relative to participants' experiences of the sick note, and was also symbolic of the care that had been put into these discussions (quotation 7). This linked with the notion that GPs' privileged biomedical knowledge, hence its power, helped with employer–employee interaction. These elements of the fit note made employees feel that a clearer case for how and when they wanted to RTW was presented to employers.

**Discussion**

Our principal finding was that employers and employees mirror each other in claiming that trust, and the flexible
application of processes, can be as important for successful RTW as physical adjustments. For employers, knowledge of employees’ track records was vital for trusting employees’ illness claims, particularly for conditions like chronic pain that may not be accompanied by objective pathology [13,14]. Employees valued having illness claims validated through the symbolic meaning of workplace adaptations and social support, which strengthened motivation to work. Both parties found it helpful to discuss the management of social interactions like “how are you?” Sickness changes socially agreed rules on when to ask this question and the often expected ‘Fine, thanks’ response. They also agreed on the positive psychological effects of changing from sick to fit note. The research literature suggests that other variables, such as company size and OH resources might be important factors in RTW, but our participants did not report that they were as important as workplace relationships.

This was a small study; its size and recruitment strategy limit the transferability of findings: results from a small non-random sample cannot be generalized; volunteers have certain characteristics that may lead to systematic bias [15]. We have provided a description of participants and their contexts, so that readers can assess if the findings apply to populations in which they are interested [16,17]. We did not explore the demographics collected in detail, which could be done with a larger, more representative study. These preliminary findings may be transferable to other contexts, such as RTW for people with other chronic, non-specific health complaints [18–20]. Our exploratory study suggests that there would be utility in further qualitative and quantitative work, to see if similar experiences were reported in different contexts.

We provide further evidence that employees found the fit note empowering in discussions with employers, as previously reported [21]. However, this earlier study found that the fit note had more impact in smaller organizations with less OH input. Here, participants reported that having positive stakeholder relationships was the most important factor in facilitating RTW, whatever the organization’s size.

Our findings are consistent with previous research showing that if managers use shared decision-making styles rather than focusing on process and instruction in RTW interviews, participants report less conflict and more effective use of workplace processes [8]. We also found that most employees valued their employers’ efforts to manage health issues at work, in agreement with previous research [22]. This is a positive finding for managing challenging fluctuating conditions, like chronic pain, at work.

Researchers and policymakers agree RTW needs good stakeholder communication [2,23]; our study suggests one important facet of this is to be open about discussing often unspoken issues, such as how employees would like to be questioned over their health status.

Both employers and employees appreciated being flexible about the guidance that exists on how to keep in contact when someone is on sick leave, an element of managing sickness absence, which often causes concern [24]. This is especially difficult for employers managing employees with chronic illness [25]. Policymakers could further highlight best practice guidance that exists on this topic [26].

The finding that the fit note was highly valued in different arenas (positive language and biomedical authority) may assist in fostering further behaviour change. Fit note guides for employees [27] and employers [28] could highlight these types of benefits, as previous research shows that multifaceted strategies are needed to change back pain beliefs and behaviours [29].

We need to know more about positive strategies used by employers and employees on a wider scale, conducting similar research with larger samples. It would be useful to research case studies in which difficult situations were turned around, as in this cohort, participants either reported on protracted difficulties [12] or, as in the results presented here, largely discussed how positive cultures that existed prior to sick leave were then utilized. We need to research the effects of the forthcoming Independent Assessment Service, designed to provide better OH resources for stakeholders [23].

The burden of chronic pain in the workplace is considerable [30] and the positive strategies presented here may help others. Trusting employees to try as hard as possible and employers to do the best possible was the most important element of successful RTW. This arose from knowing each other. We need to research how to foster this trust when stakeholders do not know each other so well and do not have positive workplace environments to build on.

Key points

- Trust in other stakeholders, as well as physical adjustment processes, was helpful for return to work in patients with chronic pain.
- The fit note was highly regarded by employers and employees for psychological and practical reasons.
- Thinking about how to manage the process and the content of enquiries about health status were useful as sick leave can disrupt social norms around this interchange.

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Conflicts of interest

None declared.

References