

How GPs in Norway conceptualise functional ability: a focus group study

Kariann Krohne and Søren Brage

ABSTRACT

Background

Loss of functional ability has been introduced as a criterion for social benefits in several European countries. This criterion may direct attention towards work ability and individual resources, and thus reduce the number of persons claiming social benefits. However, little is known about how functional ability is conceptualised by GPs.

Aim

To explore how GPs conceptualise functioning and functional ability in relation to their sickness certification practice.

Design of study

Qualitative study using focus group interviews.

Setting

General practices in Eastern Norway.

Method

Four focus groups with a total of 23 GPs were recruited via the Norwegian Medical Association. Data were analysed according to Malterud's systematic text condensation method and supported by a historical framework.

Results

Functioning was conceptualised by the GPs as physical, mental, and social ability. Of these domains, physical ability received special emphasis in the conceptualisation of overall functioning. The assessment of physical functioning was generally considered straightforward, aside from instances in which the underlying pathology proved difficult to locate. Mental ability was reportedly more difficult to assess, and the GPs used a wide array of rating scales to support assessments. Social ability was described in terms of social problems and their impact on patients' general functional ability. Relating functional ability to patients' work situation was a two-step process requiring knowledge beyond the scope of the clinician.

Conclusion

The concept of functioning is understood within a biopsychosocial paradigm, but implementing it into clinical practice and in accordance with insurance legislation proves difficult.

Keywords

ability; family practice; focus groups; function; qualitative research; sick leave; work capacity evaluation.

INTRODUCTION

At the end of the 18th century, the functional approach to understanding human illness was replaced by a biomedical model, in which clinical practice was aimed at diagnostics.¹ Although this model has generally proven valuable, it has received criticism for being inefficient in the practice of general medicine and social insurance medicine over the past decades.^{2,3} An increasing proportion of long-term sickness absence is caused by musculoskeletal disorders, mental health disorders, and subjective health complaints.⁴ In these cases, assessment and diagnosis is necessarily based on the GP's interpretation of symptoms and the patients' subjective reports, rather than on pathological changes. The biomedical paradigm has proven inadequate in accounting for work disability following many of these conditions.³ Consequently, models based on a biopsychosocial approach are increasingly receiving attention.² These models integrate a biomedical approach with a social understanding of illness, and they focus on individuals' ability to function within their environment. Hence, the functional approach is reclaiming a place in the practice of general medicine.

Several European countries have introduced loss of functional ability as an eligibility criterion in addition to disease for social benefits.⁵⁻⁷ In 2001, the Norwegian National Insurance Scheme recommended that an

K Krohne; researcher; S Brage, MD, PhD, senior researcher, Institute of General Practice and Community Medicine, Section of Occupational and Social Insurance Medicine, Faculty of Medicine, University of Oslo, Norway.

Address for correspondence

Kariann Krohne, Institute of General Practice and Community Medicine, Section of Occupational and Social Insurance Medicine, Faculty of Medicine, PO Box 1130, Blindern, University of Oslo, Norway.
E-mail: kariann.krohne@medisin.uio.no

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assessment of functional ability should be given increased importance in cases of sickness absence. The notion was that assessments of functional ability, in addition to diagnosis, would direct attention toward work ability and individual resources. The inclusion of a Simplified Functional Assessment (Forenklet Funksjonsvurdering) on sickness certification forms represented an attempt to guide assessment of this new functional criterion.

However, studies have shown that medical doctors often have difficulties in adopting a functional approach to the assessment of work ability.^{8,9} Such difficulties may be partially due to the conceptual understanding of functioning espoused by GPs. By employing a qualitative research method, this study aimed to investigate how GPs conceptualise functioning and functional ability in relation to sickness certification practice.

METHOD

Data for the current study were obtained from four focus group interviews which GPs performed between December 2003 and May 2004, in connection with a project on healthcare professionals' understanding of functioning.¹⁰

Focus group interviews

Focus groups were recruited by inviting members of continuous medical education (CME) groups for GPs in Eastern Norway. The CME groups are organised within the Norwegian Medical Association. Ninety-six per cent of all Norwegian physicians are members of the Norwegian Medical Association. Of the seven groups approached, three agreed to participate. These groups consisted of four, five, and six GPs from both urban and small town regions in Eastern Norway. The fourth group (eight participants) was established ad hoc by personal invitation to GPs working in rural areas. The four CME groups who declined to participate gave no explanation. There is no reason to believe that these groups differ from the groups that agreed to participate.

The group composition was diverse with regard to medical training, age, and sex. In total, the four groups consisted of 23 GPs (19 men and 4 women). The majority of the GPs were employed in group practices. Two had PhDs, 16 were specialists in general practice, and five had no specialist training. The proportion of specialists was above the national average of 64%.

The 90-minute sessions were conducted in primary care health centres, where the CME groups usually met. The moderator informed the participants about the study's purpose, limits of confidentiality, and the right to withdraw. The interview was guided by six open-ended questions, and participants were

How this fits in

The increased focus on functional ability and work ability has an impact on sickness certification practice in several European countries. There is a lack of qualitative research exploring how GPs have responded to this 'new' focus and how they actually conceptualise functional ability in their sickness certification practice. The practitioners' conceptualisation of functional ability appears to be influenced by the notable discrepancy between the biomedical and the biopsychosocial model as the basis for sickness certification. The discussion among Norwegian GPs regarding functional ability was shaped by the need to verify patient reports within a diagnostic system, the uncertainty surrounding unexplained medical disorders, and insufficient knowledge of work demands.

encouraged to freely discuss these. For the purpose of this paper, the primary question of interest was:

'As a health provider, what first comes to mind when you hear the term functional ability?'

The observer added supplementary questions at the end of the sessions.

Data analysis

The discussions were taped and transcribed verbatim. The analysis was performed according to Malterud's systematic text condensation.¹¹ Four steps were followed: transcripts were read to gain a contextualised impression of the discussions, and preliminary themes were chosen; units of meaning were identified and coded; the meaning in each coded group was condensed and summarised; and the descriptions of the functioning domains were generalised and supported by Foucault's theory on 'the medical gaze'.¹ Quotes are translated from Norwegian into English, and coded by group and participant number.

RESULTS

A global understanding of functioning

Participants generally endorsed a global understanding of functioning. They considered a loss of functional ability to adversely affect all aspects of the patients' lives, from daily life to work life:

'Somewhat coloured by experience — I have many old patients and patients with a wide spectrum of illnesses — I think just as much about the patient's functioning in everyday life as about work life and functioning at work ... But my immediate association [in this meeting] is that here is a setting — and that's about coping at work, sickness certifications, and functional assessments ...' (Group 2, participant 5)

Although this GP recognised the need for a more

limited scope when issuing sickness certificates, they envisioned functional ability as a comprehensive concept. Similar to the other participants, the GP identified the main domains for functional ability as physical, mental, and social functioning:

'[For me, functional ability] is mostly about daily tasks and managing the practical things — physical practical things — both at work and home. Social functioning ... is placed more in the background even though it's clear that many patients struggle with that, too. Social and mental ability represent significant issues for many of my patients.' (Group 2, participant 5)

Physical ability

Physical ability was uniformly emphasised by the GPs, and constituted the most-frequently assessed type of functioning in clinical practice. Participants reported that determining medical explanations for the patient's loss of physical functioning was a potentially straightforward task:

'Well, the issue of a purely objective functional assessment can be quite easy — if you have amputated both legs then you can't walk. If you have severe COPD [chronic obstructive pulmonary disease], you'll become tired more easily, and so on ...' (Group 4, participant 6)

Frequently, laboratory testing or radiography established the diagnosis, but since diagnosis alone rarely provided sufficient information to assess functional ability, additional tests (for example, of joint movements or lung capacity) were often conducted.

Although tests were widely used in assessment of physical functional ability, the GPs acknowledged that a patient's level of motivation could influence the results, especially when financial compensation was unsettled. GPs also reported utilising clinical observation to assess physical functioning, for example, by observing the patient walk towards the office — 'the corridor test'. The patients' conscious or unconscious malingering was reportedly difficult to manage:

'... You need to be aware of "red flags" at all times! What is the patient's agenda? What does he want with this sick leave? Is he afraid of having cancer? Is he minimising or exaggerating his problems?' (Group 1, participant 1)

Similar uncertainties might arise when the patient's symptoms remained unexplained following a series of tests. Notably, this was common in patients with musculoskeletal pain conditions:

'Let's say we have a guy who has a somewhat physically demanding job. He operates a crane or heavy machinery — and he says: "I can't do this any more — I'm all stiff and my back aches". So you do a functional assessment and you don't find anything. Then you ask for a test with a physiotherapist who cannot find anything wrong either. To be on the safe side, you perform an X-ray of his back to exclude any skeletal problems — you don't find anything so you terminate his sick-listing. He returns the following week saying his back hurts like crazy and he can no longer handle his job. Then what do you do?' (Group 2, participant 4)

Several musculoskeletal pain diagnoses were based upon the patient's subjective reports, that is, the patient's own description of symptoms and activity restrictions. Management of this type of situation reportedly caused significant diagnostic uncertainty and rendered treatment planning difficult, as well as complicating the assessment of functional ability. Such patients were often referred to physiotherapists, as these professionals were considered to have superior training in matching self-reported pain and physical location:

'I feel that my functional assessments are based on what the patients say about how they function — and if I feel uncertain ... I seek help. I ask the patients to see a physiotherapist, or request a psychiatric or psychological consultation. I use specialists ...' (Group 1, participant 2)

Mental ability

The GPs reported even greater problems when attempting to verify loss of mental ability, especially if impairments were minor:

'... I just don't understand how I'm supposed to make a statement regarding a patient's level of mental functioning except in the obvious cases in which people are very depressed and so on ...' (Group 4, participant 6)

The GPs frequently used clinical rating instruments to assess mental ability, mostly the Montgomery and Åsberg Depression Rating Scale.¹² The use of scales facilitated the diagnostic labelling necessary to secure the patients' rights to insurance benefits. It was also claimed that rating scales provided a more objective assessment of mental condition and ability, as patient scores can be compared against normative data. Furthermore, results may boost patient motivation and improve coping skills, or alternatively help patients understand that their complaints and symptoms fall within a normal range.

However, mental rating scales were not used unconditionally. Both GPs and patients feared the stigma related to mental diagnoses. To overcome this barrier, one GP made an agreement with the patient prior to filling out the scale:

'I'll say: "we'll just see what the score is, and then we'll enter it [into the form] if the score is high. If I get a four in one of the scores then we mention it. Otherwise this will not be reported in your files". I use it [the rating scale] more as a screening tool — and not as anything scientific, and I simply do not believe the depression score is necessary or relevant should they ever be involved in a case with an insurance company.' (Group 3, participant 1)

If the score indicated normal mental ability, the GP made no reference to it in the patient's files or to the National Insurance Office.

Social ability and social demands

Except for being briefly mentioned in connection with mental ability, the ability to function socially was not discussed in the focus groups. However, a solid understanding of the patient's social life, daily life, and family situation was considered important to determine overall level of functioning. Consultations regarding social problems and their negative consequences on level of functioning were frequent. Two different scenarios were discussed in the focus groups: first, the stressful life situation facing many women, in which domestic responsibilities conflicted with work demands. Second, the various stressors arising from work conflicts. Although less frequent, the GPs found this second scenario demanding, especially when due to downsizing or closure of large workplaces:

'I've had a lot of these cases lately ... They came here ... with problems and just couldn't go to work — couldn't look their employer in the face. Then you sit there like a hostage. [That] ... gave me some worries.' (Group 3, participant 1)

The GPs described various ways to handle this type of situation. One option discussed was to acquiesce and provide a fictional diagnosis on the sickness certification. Another was to explain that GPs were only allowed to certify sick leave based on medical problems. The latter was problematic, according to the participants, as refusal might provoke the patient to switch doctors.

The overall functional ability of patients already on sick leave was discussed within the framework of the social functioning domain:

'I've started to ask a bit ... "Well, what do you do now that you're on sick leave? How do you use your days?" I ask because I'd like to know what they're able to do when they're not at work. So when they've been sick-listed for a while I'll say, "Isn't it dreadfully boring? ... Should we try something else ... like graded sick leave for instance?'" (Group 1, participant 4)

The GPs encouraged patients on long-term sick-leave to keep in social contact with colleagues and employers to strengthen motivation, break social isolation, and create a more structured daily life. These recommendations were considered important in smoothing the transition back to work.

Relating functional ability to work demands

Assessing the relationship between functional ability and work demands was noted as a particularly demanding task:

'[What] operations do they perform at their workplace; what is their work? I'll have to admit ... what does this person do? I mean if he is a college professor then ok, but there are work tasks within the industries that I don't know much about.' (Group 2, participant 5)

A functional assessment was generally described as a two-step process:

'You'll have to figure out what they cannot do and if this has an impact on their job situation' (Group 2, participant 1).

A physical examination of the patient, for example by physical tests, was reportedly insufficient in determining work ability. Instead, work ability was viewed as a function of the continuous interplay between workplace demands and the patient's abilities. It was by acknowledging this relational aspect of functioning that practical problems occurred:

'It's often very difficult to assess what job demands the patient has — and relate that to what you see of reduced function.' (Group 4, participant 3)

The GPs made a clear distinction between verifying a reduced level of functioning and determining the extent and nature of the impact on a work situation, which is often unfamiliar to the certifying GP. They queried how medical professionals could be expected to identify the physical, mental, and social stressors associated with specific jobs:

'It's not like we stand around and load the patient up with weights to see if he can handle 3 kilos? Can he handle 6 kilos? ... Let's say the patient's job is to fill a machine with cardboard — so he lifts 10, 15 cardboards at a time, right? And, okay, he could choose to lift half of that — but then he'll be working too slowly! These things ... are impossible for us to assess.' (Group 4, participant 3)

Several GPs emphasised their role as medical practitioners providing expert statements on medical issues. The assessment of work-related functional ability was deemed to fall outside of their area of expertise. The GPs expressed concerns of producing an assessment of work-related functional ability of lower quality than a specialist such as an occupational therapist, or a physiotherapist. It would appear that the GPs often felt an external referral was warranted, as other specialists were deemed more competent in assessing how a patient's level of functioning may affect work productivity.

DISCUSSION

Summary of main findings

The focus group participants conceptualised functional ability as a complex and interactive construct which spanned the following three major domains: physical, mental, and social functioning. Owing to the recognised importance of relating these different domains to the patient's ability to dutifully meet work demands, insufficient knowledge regarding the nature of work tasks was viewed by GPs as an obstacle limiting both motivation and ability to conduct functional assessments. The need for diagnoses on sickness certification forms seemingly interfered with a functional approach.⁸ Also noticeable was a conflict between the biomedical and biopsychosocial models as the basis for sickness-certification practices.¹²

Strengths and limitations of the study

Consistent with the majority of Norwegian GPs, most participants were active in CME groups and worked as specialists in general medicine. Although participants reported a longer medical training than other Norwegian GPs, no other major professional or demographic differences were observed. However, it is important to exercise caution in generalising results to all GPs practising in Norway.

Aiming to create a peer-led setting, all focus group sessions were moderated by a GP researcher.¹³ The use of groups in which participants have pre-existing personal or professional relationships has been previously discussed in the methodological literature on focus groups.¹⁴ In the present study, these relationships appeared to create a supportive

environment in which participants seemed secure in sharing viewpoints.

Comparison with existing literature

GPs are trained to consider clinical results within a diagnostic framework. However, this approach has not always prevailed. Prior to the entry of modern medicine, the primary concern of medical doctors was physical functioning. Accordingly, the centre of attention was the patient as an experiencing subject.¹⁵ Foucault claims that 'a medical gaze' was developed towards the end of the 18th century, which created a divergence between diagnosis and functioning. The medical gaze is best explained as the modern doctors' ability to observe and select relevant medical information, enabling them to see the patients 'objectively', and as physical units.¹ The invention of a nosology; '... an objective, real, and at last unquestionable foundation for the description of disease', enhanced the prestige of the doctors.¹⁶ Subsequently, medical doctors liberated themselves from the more subjectively based phenomenon of functioning. Medicine has since maintained the distinction between functioning and diagnosis. Over time, diagnoses have become a question of accuracy, while level of functioning is considered a matter of subjective opinion.¹⁵ This background may help us understand why pathological findings leading to a diagnosis are a cornerstone of clinical practice.

In the present study, the GPs espoused a global and biopsychosocial understanding of functioning. The separate domains of physical, mental, and social ability often merged within clinical practice.

Physical ability is amenable to observation and examination. This may account for one participant's notion of physical ability as 'purely objective'. In many cases, the task of assessing level of functioning appears straightforward; however, it proves difficult in the absence of clinical findings. Accounting for symptoms in the absence of test results is inarguably challenging, raises concerns of malingering or professional incompetence, and often leads to referrals to specialists to assist in determining the source of patient symptoms.

Mild mental health disorders are frequent causes for long-term sickness absence.¹⁷ For GPs, these disorders may prove difficult to diagnose as they are closely linked to the patients' subjective experience. Participants in this study reported they frequently used rating scales to verify the presence of mental problems or impairment in functioning. Additionally, a level of collusion was noticeable as GPs reported agreeing to omit test results from patient files in order to secure patient consent to testing.

In line with studies by Gulbrandsen *et al*,^{18,19} this research found that the GPs acknowledged the

impact of social problems on functional ability. The participants discussed lowered functioning due to social problems, but loss of social ability itself was not mentioned. In general, the GPs interpreted problems in social functioning as external factors facilitating or hindering participation in work life. This interpretation is similar to the notion of environmental factors in the International Classification of Functioning, Disability and Health (ICF).²⁰

The results of this study highlight the ambiguity that surrounds social problems. The practitioners referred to them as both 'placed more in the background' and as 'a large issue'. GPs have previously reported that patient expectations to assist with non-medical issues are a significant source of strain or stress.¹⁹ Time constraints and their role as medical professionals may be reasons why social problems are difficult to manage. Nevertheless, participants emphasised that social factors, such as the patient's participation in the social life of a workplace, are important for a successful return-to-work process.²¹

The GPs argued that findings of impairment or disability were not always directly transferable to work situations.²⁰ The observed discrepancy between functional ability and work capacity noted here is in accordance with the findings of Krakau.⁹ Knowledge of the workplace in question is required to identify the adverse conditions at work responsible for disability. This knowledge often exceeds the professional scope of the medical practitioner. Thus, the relational aspect of functioning remains a major practical dilemma in the certification of sickness absence.

Implications for future research and clinical practice

This study underscores that the role of GPs in assessing functional status is dominated by the need to verify patient reports in medical terms, although participants acknowledged that impaired work ability may occur in the absence of diagnostic confirmation. The concept of functioning is understood within a biopsychosocial paradigm, but implementing it in clinical practice and in accordance with insurance legislation remains challenging. This is mainly due to the significant interplay between functional abilities and the practitioner's often incomplete knowledge of work demands.

An increased level of cooperation between GPs and other therapeutic specialists might prove beneficial in addressing several of these recognised challenges. The GP should also more carefully consider the work conditions and work demands of their patients when assessing the need for sickness certification. Insight into how GPs conceptualise functioning, approach

decision making, and implement practical elements into clinical practice would provide valuable information to health policy administrators.

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Ethical approval

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Competing interests

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