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How do physiotherapists perceive their role in work ability assessments? A prospective focus group study

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Background: Work ability and work ability assessments have become important both in health care and in relation to granting sick leave. There are different interpretations of work ability among the different professionals involved, and there is no consensus on how work ability should be assessed. **Aim:** The aim was to analyse how a group of experienced and specially trained physiotherapists (PTs) in primary health care (PHC) perceived their professional role in work ability assessments during 14 months. **Methods:** We conducted a prospective focus group study and applied qualitative content analysis to the data. **Findings:** There was a need to emphasise the PTs' role both within PHC and also in relation to others involved. The PHC organisation was not really prepared to direct work-disabled patients to PTs before physicians. In addition, the PTs themselves needed to reorganise to better meet the requirements. The PTs underlined the advantage of their frequent and extended meetings with patients. This made it possible to assess, follow and facilitate work ability and to determine patients' resources. The PTs believed that they could contribute to structured assessments, which was positive for themselves and also in their communication with physicians and patients. The PTs later took more initiatives in work ability questions and believed that they could be responsible for work ability assessments to a greater extent. They found it most valuable to have had the opportunity to reflect on work ability, while working in the focus groups, and also to have been the subjects for further education. This made them more prepared to handle work ability questions when compared with other colleagues.

Key words: musculoskeletal; physiotherapy; professional role; sick leave; work ability; work ability assessment

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Background

Work ability has become increasingly important in many western countries and is frequently discussed in relation to sick leave (Ahlstrom *et al.*, 2010;

Strijk *et al.*, 2011). In Sweden, an individual is entitled to sick leave benefits if their work ability is limited because of an injury or disease. How work ability is perceived among different involved parties has a major impact on work ability assessments and how sick leave benefits are granted. The Swedish Social Insurance Agency (SSIA) is responsible for the final approval of the sick leave benefits awarded and represents a more restricted,

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medical view on work ability compared with health professionals who make their judgements on the basis of a wider range of aspects (Ståhl *et al.*, 2009). The physicians involved in assessments often find it difficult to assess an individual's work ability (Löfgren *et al.*, 2007; Stigmar *et al.*, 2010), especially those physicians in primary health care (PHC) (Hussey *et al.*, 2004; Löfgren *et al.*, 2007; Winde *et al.*, 2012).

In Sweden, physiotherapists (PTs) do not issue sick leave certificates, although they occasionally contribute to work ability assessments. In other countries, for example, Norway (Lovdata, 2005; Norwegian Physiotherapy Association, 2011) and Australia (State Government of Victoria, 2011), PTs are entitled to issue sick leave certificates and decide whether a patient is able to work or not. In a previous study, PTs emphasised that there is need for further education and experience in order for PTs to be able to take responsibility for work ability assessments (Stigmar *et al.*, 2012).

An individual's work ability is defined by the different resources they possess in relation to demands imposed on them by the work they are to carry out (Ilmarinen, 2001). Fadyl *et al.* (2010) identified six broad categories that contribute to work ability. However, to date, there are no methods available that fulfil the task of making a complete assessment. As there is need to develop reliable methods and collaboration in work ability assessments (Stigmar *et al.*, 2010, 2012; SSIA, 2012), it is important to find out how different professionals perceive their role in such assessments. In this present study, a group of experienced and specially trained PTs, all at present contributing to work ability assessment at three different PHC centres in southern Sweden, were surveyed over a period of 14 months.

Aim

The aim of this study was to analyse how a group of experienced and specially trained PTs perceived their professional role in work ability assessment.

Method

This study was designed as a prospective focus group study (Krueger and Casey, 2009).

Study participants

A strategic sample of seven experienced PTs, working at three PHC centres, participated in an education programme related to insurance medicine, introduction to the International Classification of Functioning, Disability and Health (ICF) (World Health Organisation (WHO), 2001) and cognitive behavioural therapy. The sample group of PTs was instructed to offer early access to patients with neck and back problems and was trained to write structured statements concerning a patient's work ability into their medical record, on the basis of the domains in the ICF. In all, seven PTs were invited to participate in this focus group study and all accepted. The mean age of the participants was 49.4 years and their mean years of clinical experience were 25.3 years. Two of the participants were men, five were women and one was also the head of a physiotherapy unit.

Process

Five focus group interviews were conducted with all participants over a period of 14 months. At interviews number 2 and 3, one participant did not attend, and at the last interview two participants did not attend. An external PT, familiar to the participants and who had clinical experience in the field, served as a moderator. The moderator led the dialogue, aiming to facilitate and maximise interaction and to build up confidence in an interview situation (Öhman, 2005; Krueger and Casey, 2009). An assistant was present during the interviews in order to take notes, be responsible for the tape recorder and also to observe the atmosphere during the interviews (Holloway and Wheeler, 2002).

After each focus group session, there was a short debriefing, where the moderator, the assistant and the first author discussed the interview between them (Carey, 1995; Kidd and Parshall, 2000). An interview guide was used that comprised questions concerning work ability, work ability assessment and the PTs' role in work ability assessment. The interview guide was modified and developed after each focus group session (Öhman, 2005) to follow up on the previous session and to make adjustments. In between focus group session number 2 and 3, some questions for the participants to reflect upon were mailed out. Their answers were put together and used in the next focus group

session. Between focus group session number 3 and 4, the informants were asked to make appointments with the physicians at their PHC centre to find out the physicians' views of the PTs' judgements and statements concerning work ability, recorded in the patients' medical record.

The focus group sessions took place in neutral surroundings and lasted for 2 h each. After 1 h there was a short break. The sessions were audio-taped, except for the breaks. The focus group interviews were transcribed verbatim by an external person (Kidd and Parshall, 2000). The written transcriptions indicated when the moderator spoke; however, as for remaining speakers, there was no identification of who had spoken only that there were different speakers. Evidence from all five focus groups is included in at least one quotation in the presentation of the findings.

Analysis

All the written material was considered as part of the unit of analysis. The transcriptions were read through several times to form an opinion of the content. Three of the authors (K.S., C.E. and B.G.) discussed the interviews between them. Qualitative content analysis was applied to the data (Krippendorff, 2004) using an inductive, sequential analysis approach (Baxter, 1991). The data were divided into meaning units, condensed and labelled with codes (Graneheim and Lundman, 2004). For each interview, the codes were grouped together in different content areas using 'the long table approach' (Krueger, 1998). Following this, all five interviews were examined and their content categorised. Throughout the analysis, we returned to the original interviews to ensure that the categories were mutually exclusive. The first author presented a preliminary categorisation, which was further discussed between all four authors (K.S., C.E., L.B. and B.G.) and revised. The analysis went to and fro and different categorisations were tested. Finally, the categories were confirmed by all four authors and quotes from the interviews were chosen to elucidate the final categories (Elo and Kyngäs, 2007).

Ethics

This study was approved by the Regional Ethical Review Boards of Lund and Linköping, Sweden (FEK dnr 03–296, dnr M165–05, T51–07).

Findings

The aim of this study was to analyse how a group of experienced and specially trained PTs perceived their professional role in work ability assessment, over a period of time. The findings are presented in relation to four categories.

The need to emphasise the PTs' role in the organisation

The PTs reported that there was ambivalence within the PHC organisation concerning the PTs' role in work ability assessments, and that the organisation was not really prepared to direct work-disabled patients to PTs before their being seen by a physician. The PTs themselves needed to reorganise their work to better meet this situation. In general, PTs believed that they were generally trusted by the PHC organisation to assess a patient before their meeting a physician, and that in most cases physicians read the PTs' notes written into the medical record. However, there were also physicians who chose to read only their own notes and who focused on their own role when making assessments related to work ability and sick leave issues.

Also outside the PHC, there was a need to emphasise the PT role. The PTs considered that the occupational health service (OHS) was the most appropriate unit in which to make work place visits, as OHS has the responsibility for this area and also the relevant competence, which the PHC did not have. The PTs found that the SSIA did not ask for their assessments and participation in meetings and there was need to inform the SSIA concerning the PT competence:

- *I think it is a culture among nurses, to direct patients with severe problems to the physicians, since the patients might need sick leave notes and pain-relievers.*
- *... I believe if we could come together and discuss matters, we would find that we share the same viewpoint on these assessments, which at this time, we do not. And perhaps, we could look more at each other's assessments. I think this is reverse thinking, even if they (the physicians) often experience sick listing as troublesome, they still do not want to pass it up.*

Benefitting from continuity

The PTs stressed the advantage of seeing a patient frequently over a period of time and also for longer treatment periods at each visit. This was considered as being a unique aspect of the PT role compared with the physician's approach and also related to other health-care professionals, such as chiropractors. By making use of contacts over a period of time, it becomes easier to focus on a patient's whole body function and their motor skills to consider a variety of factors, such as tailor-made rehabilitation, work with behavioural changes and also to assess an individual's different resources and attitudes. Continuity made it easier to evaluate sustainability and also the risks of further work limitations if the patient should return to work. The PTs reserved a considerable part of a PT session to build up a patient's trust. The PTs also believed that continuity gave them an opportunity to give patients explanations they could understand and also the possibility to dedramatise a patient's problems and pain:

- *It is important to remember that we meet the patient... we can make follow-ups, if we think that they (the patients) should try working part-time, then they try and maybe we meet again the following week. This way the contact is very frequent, which, unfortunately, is not the case with a physician who might put a patient on the sick-list for three weeks and then make a new contact or a telephone call. We can make immediate follow-ups and thereby quickly pick up on problems.*
- *Dedramatise and make them more secure in how they cope with their problems. I have noticed over the past years, that my professional role has become more pedagogic, I have become more of a coach and apart from giving the patient regular treatment I work towards making the patient feel secure.*

Contributing to more structured assessments

The PTs commented that the additional education they received improved the way they could contribute to work ability assessments. They believed that their assessments were now more structured and that the ICF-based notes in a

patient's medical record improved their communication in PHC. The notes were not only of value to themselves but also to the physician and the SSIA. In addition, for the patients, these assessments contributed to their better understanding of whether their work ability was affected or not. Writing ICF-based notes also added emphasis to the need for reliable assessment methods:

- *When I am writing these different domains in the ICF and I should assess function; what is difficult for the patient to perform, squatting or, prolonged sitting, I carefully write my assessment down every time. I believe it must be of value to the physicians to know what is troubling the patient and put that in relation to the patient's work. This is new, before we did not express ourselves like this in the patient's medical record. I believe that this has resulted in a major increase in quality.*

Taking more initiatives

The PTs reported that they now ask more questions concerning a patient's work and did not hesitate to discuss a patient's eligibility for different types of works. Although, sometimes, the PTs expressed that there was a need to involve the physician to ensure a safe assessment. They emphasised the importance of being experienced, not only as a PT in general, but also of having experience of work-related musculoskeletal disorders and also a more broad life experience to be able to understand a patient's work situation.

The patients considered that recently graduated PTs hardly consider work ability issues at all. The participants in this study believed that an experienced PT could better contribute to work ability assessments than a pre-registered physician. The PTs found that they often accelerated the return-to-work process and took more initiatives by contacting physicians and the SSIA. The focus group meetings were found to be most valuable, as they gave the participants an opportunity to reflect and discuss work ability in a deeper sense, which was not possible in daily practice. They experienced that these discussions and their tailored education had given them an advantage. The participants perceived that they were somewhat more knowledgeable about work ability assessments than their colleagues, and therefore felt that their work ability assessments

could be relied upon to a greater extent than those of their colleagues:

- *Having several patients, and coupled to the experience that I gained from them all, has really improved my ability to make work ability analysis. I have learnt how different people react and understand that different persons react in different ways to the same diagnosis.*
- *I believe that we are now some steps ahead of our colleagues, that is to say those who are not participating in this study; we have been in this process for years, even though there have not been so many patients, but we are educated in how to think. For many (colleagues) this is a little bit scary. In the future my assessment will be the base for what the physicians will write (in a patient's medical certificate). We, the participants in this study have discussed this matter, between us, and we believe that we are all in agreement in our thoughts on the subject.*

Discussion

During a period of 14 months, five focus group interviews were conducted, and seven PT study participants expressed their perceptions of their role in work ability assessment in the PHC. Four categories were agreed upon: the need to emphasise the PTs' role in the organisation, the benefits of continuity, to contribute to more structured assessments and to take more initiative. The findings are discussed here in relation to some important areas.

PTs' contribution in work ability assessments

Physiotherapy competence in work ability assessments is often highlighted (Ståhl *et al.*, 2009; SSIA, 2012). However, PTs do not always experience that they are a requested resource in the field of work ability assessment (Stigmar *et al.*, 2012). A previous study has shown that PTs have more time reserved for each appointment when compared with physicians (Ståhl *et al.*, 2009). Holdsworth *et al.* (2008) suggested that PTs in the United Kingdom have a greater opportunity to assess work ability than physicians because of their frequent contact with patients. Physicians have expressed the importance of having an

ongoing progression plan (Stigmar *et al.*, 2010), and in this study it appeared that the PTs integrated work ability assessment into the rehabilitation interventions. The PTs highlighted the importance of dedramatising problems related to pain and such factors have been found to be valuable, if patients remained in work (deVries *et al.*, 2012). This integrative approach might be advantageous as a person's work ability changes over time (Lindberg, 2006). The PTs in this study were able to make regular follow-ups to check on sustainability and also to encourage patients to try to return to work, while, if necessary, also advising patients to slow down so as to avoid their sustaining further work ability limitations.

The ICF-based medical notes were considered to be advantageous for the PTs in their communication with physicians and the SSIA, and further in relation to patients. For some years, physicians in Sweden have been requested to describe, in the medical certificates, their patients' limitations in relation to ICF (WHO, 2001). A previous study has shown that physicians mainly consider a patient's structural, functional and participatory dimensions (Slebus *et al.*, 2007), whereas functional limitations are rarely described (Nilsing *et al.*, 2011).

Collaboration

Physicians and PTs have identified the need for more collaboration between themselves in work ability issues (Stigmar *et al.*, 2010, 2012), but collaboration relies very much on the willingness of the different personnel involved (de Rijk *et al.*, 2007). In health care, there is a hierarchy and physicians have a great impact on any team work (Shaw *et al.*, 2005) and also hold different perspectives on collaboration in work ability issues (Ståhl *et al.*, 2009). Although GPs experience conflicts in being gatekeepers (Hussey *et al.*, 2004), the informants in this study found that some physicians appear to resist involving other professionals in work ability assessments.

A more comprehensive collaboration with the OHS was requested by the PTs, as the PHC did not have ergonomic competence. Collaboration between the employer, the SSIA and the OHS has been reported to be advantageous (Kärrholm *et al.*, 2008); however, collaboration between health care and the OHS has been reported to be sparse, as these services are sometimes unavailable

(Swartling *et al.*, 2008). Previous studies have shown that there is a lack of knowledge among different health professionals in health-care organisations, concerning work places (Stigmar *et al.*, 2010, 2012; Ståhl *et al.*, 2011), but also in the SSIA (Ståhl *et al.*, 2011). There are also a lack of processes and economic incentives for different involved practitioners to collaborate with OHS (Ståhl *et al.*, 2011).

Arranging for a more extensive scope of practice for PTs

Holdsworth *et al.* (2008) have suggested that PTs might help reduce the GPs' workload by extending their scope of practice. Today, the SSIA is asking for a more collaborative approach in work ability assessments where PTs are a complementary resource (SSIA, 2012). In the present study, most of the patients who visited a PT before visiting a physician had functional limitations, but were not in need for sick leave or were already on sick leave. The PTs were found to be focused on a patient earlier in the process. Holdsworth *et al.* (2006) found that patients who referred themselves directly to PTs differed from those who were recommended to the PT by their GP, in as much as they had experienced their symptoms for a shorter period, completed the course of their treatment to a greater extent and also were less absent from work. Nordemar *et al.* (2006) concluded that early access to physiotherapy was beneficial for patients with low back pain. To arrange for early access to PTs is possible without involving additional resources. Furthermore, GPs and PTs support the idea that PTs could be the first point of contact in the management of musculoskeletal disorders (Holdsworth *et al.*, 2008).

In Norway, where specialist PTs are permitted to issue sick leave notes, there has been no tendency towards an increase in the use of this opportunity (Lippestad *et al.*, 2003). Today, within PHC organisations, other health-care practitioners such as nurses have a more extended scope of practice than earlier, and no differences were found in patient health outcomes for nurses and physicians. However, the patients seemed more satisfied with nurse-led consultations and noted that nurses gave more time for each consultation and also offered more frequent recalls (Laurant *et al.*, 2004).

Development of the PT role

The participants in this study believed that work ability assessments required both competence and experience to enable them to ask questions concerning a patient's work place. Shepard *et al.* (1999) have suggested a theoretical framework for the development of PT expertise that underlines the point that philosophy, knowledge and clinical reasoning must merge. Clinical reasoning must be taught in clinical practice, which is in line with how clinical expertise is reached (Benner *et al.*, 1999) and also how physicians learn to handle work ability issues (Löfgren *et al.*, 2011). If PTs should be more involved in work ability assessments, there is a need for further education (Stigmar *et al.*, 2012), and also tutorials in clinical practice should be available to transfer knowledge to clinical practice and develop experience. It is also important to consider whether PTs in general want to be responsible for doing work ability assessments. In a national trial in the United Kingdom, 22% of PTs reported that they did not want to be involved in work ability issues (Holdsworth *et al.*, 2008).

The PTs in this study focused on the whole body function and a variety of factors in work ability issues in line with how other health professionals perceive work ability (Hussey *et al.*, 2004; Ståhl *et al.*, 2009; Stigmar *et al.*, 2010, 2012). This assessment includes not only objective views on illness and health, but also the subjective meaning for the individual and the contextual factors, which correspond to the complex concept of work ability (Ilmarinen, 2001). Using the different domains in the ICF may contribute to a more enlightening description of work ability limitations. We believe that the participants in this study have developed their professional role, as well as the way they look at work ability assessments.

Methodological considerations

In this study, we used focus group interviews to capture different perspectives through an interactive discussion (Krueger and Casey, 2009). This methodology was used in recently published studies within the same area of interest (Hussey *et al.*, 2004; Ståhl *et al.*, 2009, 2011). We believe that the use of this method in this setting was appropriate and corresponded with the aim of this

study. All of the participants belonged to a professional group, which supported the identification of the objective of the study (Wibeck, 2000), and were committed to participating in the discussions. Repeated interviews, within the same group of participants, can contribute to tracking changes in perceptions and also deepen the discussions within a more informed group (Krueger and Casey, 2009). With respect to confidentiality, the study participants' identity has been protected. The COREQ 32-item checklist was used as a support for how the study was presented and to obtain trustworthiness (Tong *et al.*, 2007). The participants were strategically chosen and specially trained; consequently, there is a need for further studies to be able to transfer these findings into similar contexts.

Conclusions

The PTs took more initiatives in work ability assessments, following their participation in this study, and believed that they could now contribute to structured ICF-based assessments. Such involvement requires awareness of the PT role both at the PHC and also in relation to other bodies who are involved. The PTs underlined the advantage of their having frequent and extended meetings with their patients, which made it possible to assess, follow-up and facilitate work ability over time. The participants found it to be most valuable to have had the opportunity to reflect on work ability and also to become the subjects of further education on the subject of work ability assessment. They believed that this opportunity had made them more prepared to handle questions on this subject.

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