Sick Leave Questions in Telephone Nursing

Perspectives of Persons on Sick Leave and Registered Nurses in Primary Health Care

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Dissertation presented at Uppsala University to be publicly examined in Auditorium Minus, Gustavianum, Akademigatan 3, Uppsala, Thursday, 22 November 2018 at 09:15 for the degree of Doctor of Philosophy (Faculty of Medicine). The examination will be conducted in Swedish. Faculty examiner: Professor Lotta Dellve (Department of Sociology and Work Science, University of Gothenburg).

Abstract

Aim and methods: To explore experiences of being on sick leave by interviewing 16 persons on sick leave and using a phenomenological approach. To explore registered nurses’ work in the care of persons on sick leave by performing three focus group discussions with registered nurses. To explore the effect and experiences of an educational intervention in social insurance medicine with registered nurses by studying the effect of a randomized controlled study with 100 registered nurses and by interviewing 12 registered nurses who participated in the intervention.

Findings: The essential meaning of being on long-term sick leave was losing one’s independence. This loss was connected to mostly negative experiences of being absent from work, the social insurance rules, and experiences in encounters with many professionals.

The registered nurses’ work in handling sick leave questions included assessing, dispositioning, supporting, and collaborating actions. They expressed lacking competence, had different understandings of their role, and experienced stress connected to contradictory demands in their roles as carers, co-workers, and distributors of organizational resources.

The short educational intervention in social insurance medicine seemed to have had an effect, but due to the small study population, the effect was inconclusive. The process evaluation showed that the educational intervention was perceived to have contributed to registered nurses gaining role clarity in their work with sick leave questions. The registered nurses described increasing their knowledge and skills as well as taking on more of the traditional actions related to telephone nursing, for example giving more information and being more attentive, coaching, and encouraging towards patients.

Conclusions: Being on long-term sick leave can be experienced negatively, and can be connected to several dimensions of life. Registered nurses at the studied primary health care centres had a role in the care of patients on sick leave, but had different understandings of their role that affected how they handled telephone calls with them. The educational intervention failed to show a conclusive effect due to the rather small study population. However, the registered nurses experienced that participating had enhanced their competence.

Keywords: Sick leave, sickness absence, sick-listing, sick leave questions, social insurance medicine, primary health care, telephone nursing, registered nurses, phenomenology, qualitative content analysis, nominal logistic regression, educational intervention, randomised controlled trial, competence, role


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To all on sick leave
and
to all registered nurses working
with telephone nursing
Cover: Illustrations and design by
Albert Lännerström
List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.


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Before beginning my doctoral studies, I worked as a district nurse at a primary health care centre in Sweden. A large portion of my working time involved helping patients who called the centre with different questions, and some of these questions concerned sick leave. I found these questions especially difficult to answer, and there was seldom an obvious way to handle them. I also sensed that many of the patients seemed stressed and worried, but I did not really understand what it was that caused these feelings. I realized I did not know enough about sick leave, and wanted to know more and understand better so I could help them in a better way.

At that time, in that county council, it was very seldom that registered nurses (RNs) were part of the teams working with supporting patients on sick leave. Teamwork was common when it came to patients with chronic diseases, and on these teams RNs played a large role in supporting and coordinating care. But this did not apply to sick leave; the existing teams were more directed towards rehabilitation than care.

I started exploring the research area of sick leave, and rapidly discovered that there was almost no research concerning RNs’ role in this area. When I tried to discuss RNs’ role in the care of patients on sick leave, with both coworkers and other researchers, I was often met with the attitude that they are not involved in this work. Nevertheless, I spoke daily with patients who had questions about sick leave that I found problematic to handle. Hence, the clinical problems I experienced led to my research interest in this area.
Introduction

Falling ill and not being able to cope with working is an event that occurs, more or less, to all humans during a lifetime. It is an inevitable part of living to sometimes need the help of others to recover from illness. A person in Sweden who has reduced work ability due to disease is offered support by the state in a process to recovery that includes contact with several different actors. This process is complex, crosses authorities’ boundaries, and requires cooperation between all actors, including the person him/herself, to be effective.

Swedish health care professionals involved in supporting patients on sick leave often describe this work as problematic and highly challenging. Professionals who work with sick leave have therefore been targeted for extensive development in the last decade. However, RNs’ role in caring for patients on sick leave is unclear and may be underdeveloped.

Despite its complexity, the care of patients on sick leave has at its core the same challenge as all care has: to provide patients with the support they need for recovery. The professional caring of patients is foremost a question of supporting the patient’s ability to recover:

Not even the most knowledgeable, competent and professional carer can offer a patient health. The only thing a carer can do is offer health care, through which the patient can increase his/her own ability to achieve health, fight disease and other ill-health, and increase the possibility for well-being. (p. 13 (1))

This thesis explores the problematic question of sick leave in the context of primary health care from two perspectives: that of the persons on sick leave and that of the RNs.
Background

The following chapter provides an overview of research and the context of the studies, both relevant for understanding the findings. It includes sick leave, experiences of being on sick leave, professionals’ work with sick leave, and RNs’ role in primary health care, especially in telephone nursing.

Sick leave

In many modern Western societies, sick leave is seen as a large problem. This is due to its societal and personal consequences: it costs society large amounts of money, causes companies production loss, and often affects the ill person negatively if it becomes long-term (2, 3).

The Swedish social insurance is designed to provide financial security during all stages of life, and covers everyone who lives or works in Sweden. Allowances and benefits are paid to persons who are ill or disabled, to families with children, and old-age pensioners (4).

In 2017, the costs for the social insurance in Sweden were SEK 237 billion (€ 22.6 billion), whereof 55% – 127 SEK billion (€ 12.1 billion) – was for sick leave and disabilities (5).

Historically, Sweden has had among the highest sick leave rates among comparable European countries (countries with similar economies and growth: Sweden, Norway, the Netherlands, Finland, Denmark, France, Germany, and the UK). Since 2008, Sweden’s rates have been on average among these countries (6).

Sick leave rates in Sweden have varied greatly in the last 50 years. According to analyses by the Swedish Social Insurance Agency, there is no simple explanation for the recurrent variation; it is due to many different forces that interact and reinforce variation. Among the explanations are: labour force conditions, norms and the behaviour of the population, administrative resources in authorities handling benefits, and changes in regulation (7).

In 2017, sick leave rates in the labour force in Sweden were 3.2% among women and 1.8% among men (measured in Labour Force Surveys and defined as absence from work for a whole week due to illness or injury) (8). Since the 1980s, sick leave has been more common among women than men.
in Sweden (7): during 2017, 64% of sickness benefits were paid to women and 36% to men (9).

Studies on long-term sick leave show that after only a few months on sick leave, the probability of returning to work drastically decreases (2, 10, 11). The Swedish Social Insurance Agency has analysed sick leave lasting 60 days or longer, and found that the duration is related to the type of work. Nearly 50% of women on sick leave for 60 days or longer work in female-dominated occupations in welfare service, while an equal share of men work in male-dominated blue-collar occupations (12). Since the 1990s, the most common ongoing sick leave diagnosis has been psychological conditions, which also stands for the largest increase in recent years (5).

Concepts in sick leave research

Sick leave research has been conducted in many different disciplines, but seldom interdisciplinarily. There is a lack of consensus on the use of different concepts and measures within the field that can cause difficulties in comparing studies on sick leave (13).

In relation to this thesis, the use of concepts in the different empirical studies performed by the author has not been consistent. This may be partly due to the lack of consensus on the use of concepts in the field, and the fact that the specific area of RNs’ work with sick leave is new and has therefore lacked appropriate concepts to describe its parts. Another contributing factor is the development process that occurs in the course of doctoral studies. Therefore, a description of the concepts connected to sick leave used in this thesis will be described with the current understanding (Table 1).

In Study I, ‘persons on long-term sick leave’ were described as ‘long-term sick-listed persons’. In Swedish, only one concept is used to describe persons on sick leave – ‘sjukskrivna’ – which conceptually directly refers to the physician’s act of issuing sickness certificates, or in spoken language, ‘to sick-list’ (‘att sjukskrivas’). A change of the concept from ‘sick-listed’ to ‘on sick leave’ was made, as this emphasizes that the sick leave is not merely connected to this act of sickness certification but to the entirety of the sick leave process. The concept ‘sick-listing issues’ was used in Study II with the same meaning as ‘sick leave questions’, used later in Studies III and IV.

In Swedish there is only one concept for describing illness: ‘sjukdom’. However, the English language’s triad of illness, disease, and sickness gives a more complex and theorizing meaning to the concept (14-16). Illness refers to the person’s experience of ill-health, and is often connected to RNs’ area of responsibility in care and person-centred care as it includes the experience of being ill (17).

Disease refers to a condition that is diagnosed by a medical expert, and is often connected to measurable biomedical causes. However, the clinical practice also includes disease that is diagnosed without measurable cause,
instead based on the patients’ symptoms and experiences of ill-health (14-16).

*Sickness* is connected to the role the person with illness and/or disease takes on or is given. The three concepts overlap. A person can feel ill and have symptoms of illness without the presence of disease. On the other hand, a person can have a disease without feeling ill, and can be ill and have a disease without being on sick leave (14-16).

*Health* is also an important concept in relation to sick leave, as the goal of all care is optimal health in relation to the given circumstances. The World Health Organization defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (18). In caring science, the concept is described as soundness and an experience of well-being in relation to patients’ life and life circumstances, as well as the ability to perform life projects (1, 19).

Health is also an important concept in relation to nursing care, as an aspect of RNs’ role in health care is to prevent and restore health (further elaborated on in the section on RNs’ role) (20, 21) as it is one of the (consensus/core) concepts that is specific to caring science and separates it from other sciences (1, 19). The experience of health is connected to illness and disease in many cases, but not always. A person can experience health despite illness and disease, but needs to be able to handle and approach the illness in a way that allows well-being and the ability to perform life projects (1).
Table 1. Concepts related to sick leave.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Meaning in this thesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td>A condition diagnosed by a medical expert.</td>
</tr>
<tr>
<td>Health</td>
<td>A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.</td>
</tr>
<tr>
<td>Illness</td>
<td>A person’s experience of ill-health.</td>
</tr>
<tr>
<td>Sick leave</td>
<td>A person’s absence from work due to illness or disease that is self- or physician-certified.</td>
</tr>
<tr>
<td>Sick leave process</td>
<td>A continuum of ongoing intentions, actions, and relations between (and within) individuals, i.e. persons on sick leave, relatives, employers, and those working within the health services and the social insurance (p. 44, (13)).</td>
</tr>
<tr>
<td>Sick leave questions</td>
<td>Questions related to the social insurance regulations and sickness certification. The concept ‘sick-listing issues’ was used in Study I with the same meaning.</td>
</tr>
<tr>
<td>Sick-listed</td>
<td>Being on sick leave certified by a physician.</td>
</tr>
<tr>
<td>Sickness</td>
<td>A social role that is given or taken in society by a person who has illness or disease.</td>
</tr>
<tr>
<td>Sickness absence</td>
<td>A person’s absence from work due to illness or disease.</td>
</tr>
<tr>
<td>Social insurance medicine</td>
<td>The clinical practice that can lead to judgements and certificates that will later be used in decision-making regarding insurance determination (15)</td>
</tr>
</tbody>
</table>

Experiences of being on sick leave

When illness affects a person’s work ability to the degree that they cannot continue working, sick leave can be necessary. Being ill and on sick leave means facing not only the physical and emotional consequences of the illness but also the changes accompanying the absence from work (22-27). This process is often described as negative (2, 28-31). However, some persons describe that their sick leave was a time for recovery, and that support and positive encounters with health care and other authorities helped them return to work (22, 26, 32-37). Negative encounters have been experienced as having the opposite effect (38-40). In a Swedish study with 15 participants on long-term sick leave, the participants described that their own participation in the sick leave process affected their return to work (25).

Among reported negative consequences are lowered self-image, negative psychological well-being, negative financial situation, experienced exclu-
sion, shame, and social stigma (2, 28-31). In a Swedish study of 862 persons on long-term sick leave, Floderus et al. (31) describe that 81% experience negative influence on their financial situation and more than 60% negative effects on their psychological well-being, sleep, and leisure activities (31). Other studies found that sick leave causes inactivity and isolation, and when authorities and employers cannot offer support it causes long-term and irreversible absence (33, 41). In a Swedish review of sick leave research in 2004, it was observed that research on the consequences of sick leave had barely been studied (42) and that there is a need for more research.

In sum, research from the person’s perspective of sick leave shows both positive and negative experiences. Some of the negative experiences point at shortcomings regarding professionals’ attitudes in encounters. Other findings involve financial situation and psychological well-being. From an RN and health care perspective, these findings together indicate the need for a person-centred health care in which all aspects of a person’s life situation are accounted for in their care and treatment. Person-centred care means acknowledging the person behind the patient as an individual human being with his/her own meanings, beliefs and values that affect how that person wants to be cared for. It means organizing health care in such a way that it enables the person to live as well as possible with his/her illness. It also means, as a professional, behaving in such a way that the person’s meanings, beliefs, and values are considered (17).

Person-centeredness applied to the sick leave process in health care would mean inviting the patient to be a participating member of the team involved in supporting his/her recovery. It would also mean that the patient’s experiences of what is important for living a good life, what health is, and how an illness affects life are seen as equal in value to the professional perspective on what is important for restoring health (17, 43). That other factors besides recovering from illness affect return to work after being on sick leave has been found in a number of studies (25, 29, 32, 44-46).

To be able to offer a more person-centred care and give patients the support they need during sick leave, it is necessary to study their perspective and experience of the process. As patients’ illness and health are connected to their lives, the consequences of sick leave should preferably be studied from a lifeworld perspective that focuses on the lived experiences of phenomena.

In this thesis, the concept ‘patient’ is used if the text describes or refers to health care and the concept ‘person’ is used in all other contexts.

Professionals’ work with sick leave in primary health care

In Sweden, professional care of patients on sick leave is common in primary health care but also in orthopaedics, oncology, occupational health, and psychiatry (47). Forty-five per cent of all general practitioners report having
consultations considering sickness certification at least six time per week (47).

In Sweden, a sickness certificate is needed after seven days of self-certification. Physicians have the medical responsibility, and are obligated, to issue sickness certificates. Primary health care centres are also obligated to provide medical rehabilitation if needed. Rehabilitation teams often include general practitioners, physiotherapists, occupational therapists, psychologist/social workers and a fairly new function, rehabilitation coordinators.

Since the beginning of this century, rehabilitation coordinators have been gradually introduced in most county councils. They work with the improvement and coordination of examination, treatment, rehabilitation, and support of patients at risk of, or on, sick leave. The rehabilitation coordinators are also the contact between care units and to other actors in society (48).

Work with sick leave is governed through a combination of state law (4), county council guidelines, and local routines that all aim for availability as well as being person- and need-based, equivalent, and of good quality (49-52). The Swedish National Board of Health and Welfare defines good-quality care as: knowledge-based and appropriate, safe, person-centred, effective, equal, and given within a reasonable time (53).

The national guidelines governing the management of work with sick leave in health care state that sick-listing shall be a conscious and integrated part of care, and that treatment for both women and men is to have the same requirements of systematic quality and development as all other health care assignments and should provide high safety and good quality (54). The guidelines further describe that each county council and care unit should formulate goals connected to good-quality health care in the sick leave process. These could tentatively include that managers should ensure that they and their employees have the competence, dedication, responsibilities, and powers necessary for systematic quality work on sick leave. Health care staff should continuously take part in quality improvement by participating in the preparation, testing, and development of local routines and methods, risk management, and the monitoring of goals and results. The guidelines further state that sickness certificates should be issued in a dialogue with the patient and with respect for human dignity (54). At the time of this thesis, local guidelines for the studied county council described a recommendation that all units that issue sickness certificates have locally adjusted written routines.

In the last decade in Sweden, much effort has been made to decrease the large numbers of sick-listed persons. Since 2006, economic compensations of up to SEK 1 billion (€ 108 million) have been allocated to county councils yearly to serve as incentives to improve quality and efficiency in the sick leave process in health care (55).

Actions for improving quality have been directed at professionals’ work, the coordination of involved actors, and management. There have also been
changes to regulation and policy that have affected professionals’ work with sick leave, not only in health care but also within other authorities involved in the process. Examples of actions are the development of web-based ‘Guidelines for sick leave’ (Försäkringsmedicinskt beslutsstöd, (56)), introduced in 2007 by the Swedish National Board of Health and Welfare. These guidelines contain recommendations on sick leave duration that are to guide sickness certification. They also recommend that they be used in a way that enables the patient’s participation in the process, and state that good communication between patient and physician are central to this (56). Other actions are electronic sickness certificates, structures for cooperation between involved actors, management development, the introduction of rehabilitation coordinators, and the education of professionals (55).

The sick leave process
The sick leave process starts when a person reports sick to his/her employer or the Swedish Social Insurance Agency, and ends when the person returns to work, or receives a disability pension or other support (for example, income support or labour market measures). The process can be described as ‘a continuum of ongoing intentions, actions, and relations between (and within) individuals, i.e. persons on sick leave, relatives, employers, and those working within the health services and the social insurance’ (p. 44, (13)).

If the sick leave is long-term, the process is often complex since many different actors – health care, the Swedish Social Insurance Agency, the employer, the Public Employment Service, and the municipality – interact to enable the person’s restoration of health, work ability, and return to work.

The Swedish Social Insurance Agency is responsible for assessing the claim for allowance and coordinating all rehabilitation measures. The employer or the Swedish Social Insurance Agency (if the person on sick leave is unemployed) is obligated to provide sick pay for the first 14 days of sick leave. After this period, the Swedish Social Insurance Agency continuously evaluates and pays sickness benefits according to a structure called the ‘Rehabilitation chain’ (‘Rehabiliteringskedjan’) (4). For the first 90 days of sick leave, the person’s work ability is assessed in relation to his/her regular work. After this (Days 91-180), work ability is assessed in relation to other work tasks at the person’s workplace. From Day 181, the person’s work ability is compared to the whole labour market (4).

Physicians’ and rehabilitation teams’ experiences of work with sick leave
Both internationally and in Sweden it is well known that physicians, and especially general practitioners, find the task of issuing sickness certificates problematic (57, 58). Problems are related to the physician’s dual role as the patient’s carer on the one hand and as a medical expert when issuing the
sickness certificate on the other (59-63), lack of time (64), and lack of education (62, 65). Cooperation and communication with other stakeholders both internally and externally (65, 66), assessment of work ability (59, 65), and handling situations when the physician and the patient have differing opinions about the need for a certificate are also experienced as problematic (59, 67-69). To a high degree, Swedish physicians regard handling sickness certification as a work environmental problem (64).

In a focus group study by Nilsing (66), other professionals (physiotherapists, occupational therapists, social workers) describe that, although they do not sickness certify, they often have to discuss and defend physicians’ decisions on certificates with patients. They also describe having three strategies when handling a patient with a request for a sickness certificate: treating the patient and then refer to a physician without being involved; talking to a physician about the request; and challenging the request.

Cooperation is described by members of rehabilitation teams, physicians and social insurance officers as facilitating but also problematic, both within and outside the primary health care centre (59, 66, 70, 71).

**Registered nurses’ experiences of work with sick leave**

There is only one previous study describing RNs in relation to sick leave. In this Swedish study by Müssener (72), 35 RNs describe experiences of handling sick leave questions in telephone calls after an educational intervention in insurance medicine. The intervention consisted of two days of training and group discussions about the welfare society, social insurance medicine, the Swedish Social Insurance Agency, and sickness certificates. The RNs perceived the training as very useful in their work. After the intervention they informed the caller to a higher extent about sickness insurance rules, and felt they asked patients more questions to awaken the patients’ own responsibility. Cooperation with other professionals also increased.

These findings indicate that educational interventions seem to be a way to enhance competence in handling sick leave. If RNs had more knowledge of the sick leave process and were more secure in their role in their work with sick leave, this would hopefully lead to increased quality of care in telephone nursing.

**Registered nurses’ role in primary health care**

There is, to my knowledge, no available description of RNs’ role in today’s primary health care in Sweden. Instead, RNs’ roles in practice are often described as tasks. The most common tasks for an RN in primary health care in Sweden are: telephone nursing, working at general and specialist clinics, and providing child health care (73).
Role theory describes that roles are something other than simply tasks to perform. Roles are ‘a set of behavioural expectations attached to a position in an organized set of social relationships’ (98, p. 507). Thus, roles inhibit characteristic behaviours, social positions and expectations (74). The behavioural expectations promote or prohibit certain attitudes and behaviours attached to the role. The behavioural expectations form how a person constructs the meaning and character of the role, the role identity. The role identity functions as a framework for how the person will interpret in-role and extra-role behaviour. Thus, an RN’s role is formed by expectations from surrounding relationships connected to the organization, but also by how the RN understands and interprets the role. However, what complicates things is that employees often have more than one role in their work due to the many transactions and relations that are an inherent part of organizations (75).

It is of importance for the well-being of the role taker that the role is clear to him/her; that is, that the behaviours, positions and expectations related to the role are clear. If the role expectations are unambiguous, the role is clear to the role taker and he/she has role clarity. If not, role ambiguity – uncertainty as to expected behaviours and attitudes – is evident.

There is rather extensive research showing that role clarity positively influences job performance, organizational commitment, job satisfaction and self-efficacy (98). Evidently, role clarity is an important organizational factor to address, especially if a person holds multiple and sometimes contradictory roles in their assignments.

Consequently, there are roles that imbue expectations attached to the work performed by RNs at primary health care centres. These expectations will affect how the tasks are performed. Further, RNs have more than just one role connected to their work; hence, many different expectations are connected to RNs working in primary health care.

The most obvious role involving RNs in primary health care is that of a professional RN: performing independent care to promote health, prevent illness, restore health, and alleviate suffering through identifying and meeting patients’ needs (20, 21).

As described above, RNs have several roles in primary health care, and one of these is performing nursing care via telephone, telephone nursing. Telephone nursing is a large part of RNs’ work in primary health care centres, often occupying half their working time (76). The special circumstances framing telephone nursing will now be described.

Telephone nursing
Telephone nursing exists in almost all health care sectors in Sweden. The service was introduced in Swedish health care in the late 1960s, to make it more effective by providing self-care advice, guiding patients to the right level of care, and saving time (77, 78). The two largest suppliers in Sweden
are the local telephone nursing provided at primary health care centres and Swedish Healthcare Direct (1177 Vårdguiden), a nationally coordinated telephone health service with the same telephone number for the entire country. Most primary health care centres in Sweden have provided their own telephone nursing since the 1970s, and receive approximately 20 million calls yearly (79, 80). In comparison, Swedish Healthcare Direct, started in 2003, receives 4.5 million calls per year (81, 82).

Described effects of telephone nursing include increasing access to health care, cost-effectiveness, enhancing quality of care, enhancing self-care, and an experience of safety (83-85). Callers who have been reassured or feel safe after the telephone call are more satisfied with the care, and the RN's personal ability to encounter the caller affects the adherence to the advice offered (84-86). Today, telephone nursing is highly prioritized by the Swedish state as a means to provide availability to care. The service is often connected to quality goals, and subsequently primary health care centres who fail to reach availability goals are fined (52).

Performing telephone nursing is described as a challenging task that demands the competence to make the right assessments and decisions during the calls (87-90). In the context of primary health care, telephone nursing requires a broad general knowledge of nursing, communication, pedagogy and medicine, but also of local routines and organizational responsibilities (88, 91). Handling sick leave questions demands additional knowledge of the sick leave process and of the patient’s perspective of being on sick leave.

Telephone nursing differs from other types of nursing, as the care and assessments are based on the auditory impressions in the call (89, 92, 93). Difficulties are described as being related to not seeing the caller and making assessments based on only listening, balancing demands while being both carer and ‘gatekeeper’, having a high workload, handling calls involving language difficulties, and basing assessments on second-hand information (89, 92-99).

The concept used for telephone nursing in Sweden has mainly been the Swedish word ‘telefonrådgivning’ and a translation of the concept into English gives ‘telephone advice’. The use of this concept is somewhat misleading, though, as it indicates that telephone nursing consists of merely giving advice; thus, the Swedish concept does not reflect the complexity of telephone nursing. This is why the use of the concept ‘telephone advisory services’ in Study II of this thesis was replaced with ‘telephone nursing’ in Studies III and IV. Another concept that has been changed during the course of this thesis is the concept ‘nurse’, used in Study II to describe RNs; in the later Studies III and IV this was changed to ‘registered nurse’. This change in concept use was made to emphasize that in Sweden, a fully qualified RN with the skills and qualifications the profession requires needs to be licenced
by the Swedish National Board of Health and Welfare to have the right to practice.

As described, telephone nursing demands high competence to provide high-quality work. Traditionally, competence is defined as the knowledge, skills and attitude needed to attend to a work task. However, the view of how competence is built and developed differs between different fields of science and depends on epistemological premises. The traditional definition is based on viewing competence as attributes of the individual and tasks to be performed (100). These attributes can be achieved separate from the practice in which they are applied. However, predominant competence theories used in nursing research take on a different perspective that derives from philosophy and sociology scientists using phenomenology to understand humans and phenomena in the surrounding world (101-103).

Jörgen Sandberg, an organizational scientist (building on Donald Schön’s (102, 103) and Patricia Benner’s theories (101)), adds to competence theory a different dimension than a traditional one, expanding it to include the concept of understanding of work. Sandberg has studied engineer workers to identify essential aspects of the concept of competence (100, 104). His studies confirm Schön’s and Benner’s previous findings are that competence does not primarily consist of attributes but is rather linked to the practice by the experience in practice. Sandberg found that workers experience their work in different ways. How they experience and make meaning of the work – how they understand it – influences how they perform work and develop competence. Competence development should thus be directed towards the worker’s experience and understanding of the work to be more successful. A change in understanding can be achieved by directing competence development to the lived experience of practice. Lived experience of practice includes all aspects of practice; not only doing but also being. Learning to ‘do’ a profession and to be a professional forms one’s professional identity (100). By alternating between experiencing aspects of practice and the practice as a whole, the professional can develop an understanding not only of what to do but also of what it is to be a professional. Therefore, Sandberg’s definition of competence as knowledge, skills, attitude and understanding of work is used in this thesis.

The notion that the work in telephone nursing can be understood in different ways has been studied by Kaminsky, Rosenqvist and Holmström (2009). In a phenomenographic interview study with 12 telephone nurses working at a call centre in Sweden, it was described that the telephone nurses understood work in five different ways: 1) Assess, refer and give advice to the caller; 2) Support the caller; 3) Strengthen the caller; 4) Teach the caller; and 5) Facilitate the caller’s learning. Some of the telephone nurses described only one of the ways of understanding their work, some several, and some all (88). The findings indicate that since there can be different
ways of understanding the work, there is a need for education and training to ensure that telephone nursing is performed according to the purpose and goals of the service.

The telephone nursing process
Telephone nursing, like all other nursing, follows the nursing process steps: assessment, diagnosis, outcomes/planning, implementation, and evaluation (1, 105, 106). Telephone nursing researchers often describe these stages with different concepts adjusted to the telephone communication situation. In the setting where the studies of this thesis were performed, RNs in telephone nursing work using a dialogue process consisting of five phases: open, listen, analyse, motivate, and close (107). This process, called ‘samtalsprocessen’, was developed within Swedish Healthcare Direct, and is experience-based rather than research-based (82). The decision in the process is guided by a computerized decision aid. The recommended call duration is seven to eight minutes, and the studied county council primary health care centres are charged penalty fees if their availability rates are lower than 90% (52).

Greenberg (87) and Rutenberg and Greenberg (90) describe the process of telephone nursing in a three-phase model: gathering information, cognitive processing, and output (Figure 1). The phases commonly occur in sequence, but can also take place interchangeably. The goal is to identify and meet callers’ needs. During the calls, interpreting links all actions in the process, implicit and explicit information is translated into health care information, and health care information is translated into a language the caller can understand.

Several factors influence the process. Prioritization and call complexity: Calls concerning acute conditions are shorter as they do not require the same information gathering or cognitive processing. On the other hand, more complex problems that are not easy to assess require more information and more processing. RN resources: the telephone nursing process is influenced by knowledge, personal and professional experience, and the level of comfort (related to confidence) in handling the symptoms/diseases that occur. Organizational resources, availability of resources like decision support tools, roles of the physician or other professionals, and appointment times impact the decision-making. Validation, the possibility to learn constantly from formal and informal feedback and to increase existing knowledge, is an important factor in developing high-quality telephone nursing.
The phases in the process of telephone nursing are:

**Phase 1: Gathering information**
During the first phase, the RN gathers information to be able to assess the needs of the caller. The RN first opens the call and then tries to get to know the caller by actively listening, questioning, and redirecting. Information-seeking deepens the understanding of the caller’s needs. A secondary gathering may occur at the end of a call, or after a call, if the RN needs new information or clarification.

**Phase 2: Cognitive processing**
In Phase 2, the gathered information is cognitively processed and the priority of the need is determined by the RN. Then a decision is made and continuously the RN thinks ahead about feasible measures.

**Phase 3: Output**
Phase 3 consists of output nursing actions to meet the caller’s needs. The dispositioning outputs are explicit, for example booking appointments or referrals, whereas supporting and collaborating are mainly implicit. Supportive outputs include reassuring, encouraging, validating and teaching the caller, and after care includes information about how to get in touch with health care if necessary. The RN and the caller also collaborate if needed, for ex-
ample if there is a practical problem with implementing the chosen output. If the RN or caller is uncomfortable with the chosen output, a follow-up can be made at a later time. After this, the RN closes the call.

Sick leave questions are not mentioned or problematized in either ‘samtalsprocessen’ or Greenberg’s model (87). This is understandable, as these models have a more overarching perspective. However, encountering patients on sick leave over the telephone places special demands on RNs, as these patients are in a vulnerable position and sick leave questions are complex.

Rationale

Research describing how persons experience being on sick leave, the consequences of sick leave, and encounters with actors involved in the sick leave process is scarce. The studies that do exist describe both positive and negative experiences in relation to encounters with actors. Sick leave affects life negatively concerning several factors, including social relations and psychological well-being. The negative experiences cause suffering for the person on sick leave, and also obstruct his/her return to work. The existing studies do not focus on the inside perspective by examining the experiences of the persons from a lifeworld point of view.

RNs handle sick leave questions in telephone nursing on a regular basis, but have not been recognized for being a part of patients’ sick leave process. They have also, to a small extent, been involved in competence development and improvement work concerning sick leave. The professional work with sick leave in primary health care has mostly been studied from the social insurance medicine perspective of the clinical practice of physicians. However, RNs’ role in the sick leave process when handling sick leave questions in telephone nursing is something different from physicians’ clinical practice of diagnosing and treating patients and issuing sickness certificates. RNs perform care through the encounter on the telephone, with the aim to facilitate for the patient to have the best possible health under the circumstances and also to alleviate suffering connected to ill-health. How this care is performed is unknown.

It is also unknown whether nursing connected to handling sick leave questions differs from other questions handled in telephone nursing. Neither is it known how the RNs experience this work or what is included in the work.

The idea behind this thesis is that RNs could play a larger role in the sick leave process at primary health care centres if they were offered competence development. If RNs’ role in caring for patients on sick leave in telephone nursing is clarified and strengthened, this might benefit not only the RNs but ultimately also the patients on sick leave.
Overall and specific aims

The overall aim of this thesis was to explore experiences of being on sick leave, to explore registered nurses’ role in the care of patients on sick leave, and to explore the effect and experience of an educational intervention in social insurance medicine with registered nurses.

Specific aims

The aim of Study I was to describe, analyse and understand long-term sickness-absent people’s experiences of being sick-listed.

The aim of Study II was to describe primary health care centre nurses’ experiences of the daily dealing with sick-listing issues in telephone advisory services.

The aim of Study III was to research the effect of an educational intervention in social insurance medicine on registered nurses who experienced problems with sick leave questions in telephone nursing.

The aim of Study IV was to describe how a short educational intervention in social insurance medicine was experienced by registered nurses and what changes it brought to their work with sick leave questions in telephone nursing.
A combination of research methods was applied to reach the aims of the different studies in this thesis (Table 2). In Studies I, II and IV the aims were to describe experiences and broadly collect data that, in a nuanced way, could describe different aspects of knowledge areas that had only sparsely been described before. Qualitative data collection and analysis methods were therefore chosen, as they offer the opportunity to gather rich and varying descriptions. The interview techniques applied were: focus group discussions, individual telephone interviews, and individual interviews. All these techniques carry the advantage of potentially producing rich data, which could be used to describe the experiences being studied.

In Study I the experience of being on long-term sick leave was seen as an event affecting the person’s whole life (their lifeworld). A phenomenological approach inspired by Giorgi was used to study, analyse and describe the experiences of the phenomenon of being on long-term sick leave. Studies II and IV were analysed using manifest content analysis, inspired by Granheim and Lundman.

The aim in Study III was to study the effects of an intervention. For studying effects, quantitative methods are suitable. Participating primary health care centres were cluster randomized to avoid contamination of the educational knowledge among RNs within primary health care centres. Data were collected through surveys on two occasions, and were analysed using three varieties of nominal logistic regression.
<table>
<thead>
<tr>
<th>Study</th>
<th>Aim</th>
<th>Study population</th>
<th>Year data collection</th>
<th>Participants</th>
<th>Data collection</th>
<th>Analyses</th>
<th>Main findings /outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>To describe, analyse and understand long-term sickness-absent people’s experiences of being sick-listed</td>
<td>All (37) patients on long-term (&gt;3 months) sick leave at three PHCCs in one county in central Sweden</td>
<td>2011</td>
<td>16 patients</td>
<td>Individual interviews</td>
<td>Giorgi’s phenomenological method</td>
<td>The experiences were mostly negative and linked to the consequences of stopping working, of social insurance rules, and of negative encounters with professionals.</td>
</tr>
<tr>
<td>II</td>
<td>To describe primary health care RNs’ experiences of the daily dealing with sick-listing issues in telephone advisory services</td>
<td>RNs working with telephone nursing from three PHCCs in one county in central Sweden</td>
<td>2009</td>
<td>14 RNs</td>
<td>Focus group discussions</td>
<td>Manifest content analysis</td>
<td>The handling of SLQs was described as RNs’ actions that were affected by enabling and obstructing conditions.</td>
</tr>
<tr>
<td>III</td>
<td>To study the effect of an educational intervention in social insurance medicine on RNs who experienced problems with SLQs in telephone nursing</td>
<td>All RNs working with telephone nursing in one county in central Sweden</td>
<td>2014-15</td>
<td>100 RNs</td>
<td>Questionnaires</td>
<td>Logistic regression analysis</td>
<td>The OR for those who experienced problems regarding SLQs at the end of the follow-up in the intervention group, compared with the control group, was 0.32 with 95% CI 0.08–1.28, p=0.11.</td>
</tr>
<tr>
<td>IV</td>
<td>To describe how a short educational intervention in social insurance medicine was experienced by RNs and what changes it brought to their work with SLQs in telephone nursing</td>
<td>All RNs working with telephone nursing in one county in central Sweden</td>
<td>2015</td>
<td>12 RNs</td>
<td>Individual telephone interviews</td>
<td>Manifest content analysis</td>
<td>The intervention had increased knowledge and skills, and allowed RNs to gain role clarity in the work with SLQs in telephone nursing.</td>
</tr>
</tbody>
</table>

1 RN = registered nurse; 2 SLQ = sick leave question; 3 PHCC = primary health care centre; 4 OR = odds ratio; 5 CI = confidence interval

Design, participants and data collection

All studies were performed in one county in central Sweden. The county was chosen out of convenience, since the research group had access to the county council. There are 280,000 inhabitants in the county, which has both rural and urban areas. The primary health care centres involved in the studies are
Study I: A descriptive interview study with a phenomenological approach

Study I was an interview study with a phenomenological approach and a descriptive design. As the aim was to study and describe the experience of the phenomenon of being on sick leave, a phenomenological approach was suitable (108, 109).

Phenomenology research has its origin in the philosophical work of Husserl (110), and offers the possibility to study a phenomenon as it is experienced by a subject. The phenomenon of interest is studied in a person’s everyday life, the lifeworld. According to phenomenology, the lifeworld is filled with unreflected, subjective and perceivable experiences of phenomena. Experiences of phenomena are formed when human (subject) consciousness processes (noesis) are directed at (intentionality) an object (phenomena) and the meaning of the object appears (noema) (110). The philosophy has developed into also being an empirical method that is often used by nursing researchers (109, 111, 112).

To do justice to the subjects’ experiences, the researcher tries to reduce the influence of positing preconceived ideas about the object, by adopting a phenomenological attitude that includes trying to see the phenomenon as it presents itself to the subject and holding back any preconceived ideas. The researcher can then describe and reflect on the meaning of the phenomenon and form a description of it. Sometimes this description arrives at an essence, a core, of the phenomenon (108, 113-115).

Individual interviews were chosen to capture the experiences of being on long-term sick leave. Interviews are suitable when collecting individual descriptions of lifeworld experiences (111, 116). A semi-structural interview guide was developed. The interview started with the question ‘Can you tell me how it was when you were sick-listed?’ Subsequent areas of inquiry were how the sick leave had affected their life and relations, and how they experienced the encounter with professionals.

The sampling was purposive (109), and aimed at capturing varying descriptions of the experience. The research group believed that a sample with persons on sick leave from municipalities with differing rates of sick leave could offer a variation of experiences. All patients on long-term (more than three months) sick leave, 37 patients, at three primary health care centres in three different municipalities were invited to individual interviews. Participants were first invited by letter, and then after two weeks by telephone, to consent to or decline participation.
Seventeen of those invited agreed to participate, but one of them did not come to the interview and then declined. Sixteen of those invited declined participation, and four did not answer the telephone call. Consequently, the sample consisted of 16 participants (nine women and seven men). Self-reported causes of being on sick leave were psychiatric problems, back/neck/musculoskeletal problems, and cardiovascular problems. The participants’ ages varied between 31 and 64 years, and three of them had been born abroad but had lived in Sweden since childhood. Before the sick leave period one was unemployed, three were self-employed, one was a student, and eleven were employed (Table 3).

The interviews were performed at a learning centre and at two libraries near the participant’s residence, and were recorded digitally. Average duration of the interviews was 40 minutes, varying between 16 and 61 minutes.

Table 3. Characteristics of participants in Study I.

<table>
<thead>
<tr>
<th>Age</th>
<th>Months of sick leave</th>
<th>Education</th>
<th>Cause of sick leave</th>
<th>Degree of sick leave</th>
<th>Gender</th>
<th>Ethnicity</th>
</tr>
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<tbody>
<tr>
<td>43</td>
<td>5-11</td>
<td>2</td>
<td>1, 5</td>
<td>Part-time</td>
<td>Male</td>
<td>Foreign</td>
</tr>
<tr>
<td>61</td>
<td>3-5</td>
<td>1</td>
<td>4, 5</td>
<td>Part-time</td>
<td>Male</td>
<td>Foreign</td>
</tr>
<tr>
<td>62</td>
<td>&gt;12</td>
<td>3</td>
<td>1, 2, 3</td>
<td>Part-time</td>
<td>Female</td>
<td>Swedish</td>
</tr>
<tr>
<td>57</td>
<td>&gt;12</td>
<td>3</td>
<td>1, 5</td>
<td>Part-time</td>
<td>Female</td>
<td>Swedish</td>
</tr>
<tr>
<td>60</td>
<td>3-5</td>
<td>2</td>
<td>1, 5, 6</td>
<td>Full</td>
<td>Male</td>
<td>Swedish</td>
</tr>
<tr>
<td>37</td>
<td>&gt;12</td>
<td>5</td>
<td>3</td>
<td>Full</td>
<td>Female</td>
<td>Swedish</td>
</tr>
<tr>
<td>48</td>
<td>&gt;12</td>
<td>2</td>
<td>1, 2, 3</td>
<td>Part-time</td>
<td>Female</td>
<td>Swedish</td>
</tr>
<tr>
<td>53</td>
<td>&gt;12</td>
<td>6</td>
<td>2</td>
<td>Part-time</td>
<td>Male</td>
<td>Swedish</td>
</tr>
<tr>
<td>63</td>
<td>&gt;12</td>
<td>4</td>
<td>4</td>
<td>Full</td>
<td>Female</td>
<td>Swedish</td>
</tr>
<tr>
<td>61</td>
<td>&gt;12</td>
<td>1</td>
<td>6</td>
<td>Full</td>
<td>Male</td>
<td>Swedish</td>
</tr>
<tr>
<td>36</td>
<td>&gt;12</td>
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<td>2</td>
<td>Part-time</td>
<td>Female</td>
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<tr>
<td>63</td>
<td>5-11</td>
<td>5</td>
<td>6</td>
<td>Full</td>
<td>Female</td>
<td>Swedish</td>
</tr>
<tr>
<td>46</td>
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<td>1</td>
<td>Part-time</td>
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<td>Swedish</td>
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<tr>
<td>52</td>
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<td>Full</td>
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<td>64</td>
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<td>Full</td>
<td>Female</td>
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<tr>
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<td>&gt;12</td>
<td>1</td>
<td>1</td>
<td>Part-time</td>
<td>Female</td>
<td>Swedish</td>
</tr>
</tbody>
</table>

*Education, self-reported: 1 = Elementary school or equivalent; 2 = 2 years of high school or vocational school; 3 = 3-4 years of high school; 4 = University or college, 2.5 years or shorter (<180 HP); 5 = University or college, 3 years or longer (≥180 HP); 6 = Other education. *

Cause of sick leave, self-reported: 1 = Back/neck; 2 = Depression; 3 = Other mental diagnosis; 4 = Cardiovascular; 5 = Accident; 6 = Other.
Study II: A descriptive focus group discussion study

Study II was an interview study with a descriptive design. A descriptive design can be used when little is known about a phenomenon (109), and this was suitable as research in this area is sparse. To gather a variety of experiences, focus group discussions were conducted (116, 117). The research group had experienced that RNs were not often involved in discussions or reflections about sick leave, and therefore believed that group discussions would be a good way to facilitate and stimulate the participants to talk about it. If it works as intended, the interaction that can occur between participants in focus group discussions can influence and stimulate participants to share perceptions and attitudes concerning the discussed topic. It is also a time-effective way to gather a great deal of information in a short amount of time. The goal is not to reach consensus but rather to acquire both similar and diverse experiences (107, 110). The groups are led by a moderator (the present author), and can also include an observer who participates to observe and document nonverbal communication (117). Here, due to a lack of access to an observer, only the moderator was present.

The moderator takes on more of an observer’s role in focus group discussions than in individual interviews by initiating topics, listening, facilitating the discussion, and making sure all participants have the opportunity to share their thoughts (116, 117).

The sampling of RNs was based on convenience (109). At the time, the first author was working as an RN in the county where the study was being conducted and therefore had access to the primary health care centres in the county. The head manager of the county council-operated primary health care was contacted with a request for access to three primary health care centres. Inclusion criteria were having more than five RNs working with telephone nursing at the centre. Managers at three recommended centres were then contacted for consent to contact their RNs and to interview them during working hours. All RNs working with telephone nursing at these centres were invited by email to participate in an information meeting. Those who consented participated in focus group discussions, which were held at the RNs’ workplace and recorded digitally. Fourteen RNs participated in three focus group discussions including five, three and six participants, respectively. The RNs were 31 to 65 years old and had varying experience of telephone nursing, between 1 and 30 years.

A discussion guide was developed and tested in a pilot focus group discussion, but this did not result in any alterations to the guide. The discussions started by an introduction by the moderator. The moderator described the topic of the discussions very briefly and set the rules for the discussions. The starting question was ‘How do you come across sick leave questions in telephone nursing?’ Interaction with the patient on sick leave, frequently
asked questions, difficulties and facilitating factors as well as cooperation with other professionals were also discussed.

Study III: An explorative effect study of a randomized controlled educational intervention study

Study III was an effect study of a cluster randomized controlled trial. An explorative design was used, as the aim was to study whether an intervention could cause a change in reported experiences by the RNs. The thesis author was contacted by a county council’s Committee of Social Insurance Medicine and asked to be part of a group of clinicians and researchers who would arrange an educational education for RNs in social insurance medicine. This gave the opportunity to design a randomized controlled trial (109). However, individual randomization was judged to not be feasible, whereas cluster randomization on the primary health care centre level was. Cluster randomization has the advantage of decreasing the risk of intra-cluster contamination (contamination of the educational message from the RNs receiving education to control RNs) (118). Hence, primary health care centres were chosen as clusters and were randomly allocated to intervention or control.

A comprehensive questionnaire was developed containing 120 questions to address RNs’ work with sick leave questions in telephone nursing. The questions were taken mainly from a national survey that is used regularly to study Swedish physicians’ work with sick leave (119, 120). The questions that were used were adjusted to address RNs. The questionnaire also included demographic questions and attitude questions regarding the social insurance. The attitude questions came from another national survey (121). The questions have not been validated, but were tested for face validity on a sample of six RNs. After the test, the wording of some questions was elucidated and the layout was adjusted to facilitate the reading and answering of the questionnaire.

Managers of 26 primary health care centres in one county of central Sweden were contacted to request their RNs’ participation in a questionnaire survey (Figure 2). Twenty of the managers agreed and provided a contact person at the centre who would assist the researchers in distributing and informing about the survey. The contact person was given information about the survey and its implementation, and in turn informed the eligible RNs (100) both orally and in writing about the study. The inclusion resulted in 28 intervention group participants and 39 control group participants. Questionnaires were answered at baseline and after six-month follow-up.

Educational Intervention

The educational intervention aimed at increasing knowledge of the Swedish social insurance and different actors’ role in the sick leave process, as well
as enhancing knowledge by reflecting on practice; hence entailing competence development for the participating RNs. The Committee that ordered the educational intervention had some restrictive demands: firstly, that all RNs working with telephone nursing in the county should be offered the educational intervention; and secondly, that it could not exceed eight hours in total.

Figure 2. Flow diagram of inclusion. \(^1\)PHCC = primary health care centre; \(^2\)RN = registered nurse

The educational intervention was designed as two four-hour sessions a month apart and included lectures, group discussions, and a reflection assignment. A combination of interactive and didactic education was chosen, as this has been shown to be more effective in improving professional practice than simply didactic education (122). Reflections are often used to de-
velop professional knowledge in nursing (123-125), and among the outcomes are improvement of practice, acceptance of professional responsibility, and growth (125). Two sets of the same sessions were held during the autumn of 2014 to enable as many as possible of the eligible RNs to participate. The educational intervention was provided by clinically active professionals, as interprofessional education has been reported to have positive outcomes for professional practice (126). The educators were a district nurse active in telephone nursing in primary health care (the present author), a rehabilitation specialist physician active in primary health care, a coordinator for the sick leave process in the studied county council, and an official from the Swedish Social Insurance Agency.

The educational part of the intervention contained:
- Telephone nursing related to sick leave
- The patient’s experience of sick leave
- The Swedish social insurance
- The responsibility of health care
- The Swedish Social Insurance Agency’s responsibility
- The physician’s and rehabilitation coordinator’s role
- Local sickness absence figures
- Risk factors for long-term sick leave

Between the sessions, the participants were asked to do a written reflection assignment about a telephone call with a sick leave question. Their reflections were used in group discussions at Session 2.

Study IV: A descriptive telephone interview study

Study IV was an interview study with a descriptive design. As the data collection aimed at gathering varying descriptions of experiences of participating in an educational intervention, individual interviews seemed suitable. In interviews, interviewer and participant interact with the goal of producing knowledge about the area of interest (111, 116). The interviewer is a tool in the process, and has the opportunity to probe and reflect in order to stimulate the participant to provide rich descriptions (111, 116). Of the 28 RNs participating in the intervention (Study III), 12 were sampled for maximum variation (109) (Table 4).

The RNs were interviewed individually by telephone. A researcher who not had participated in the educational intervention performed the interviews. Telephone interviews have the disadvantage of being based on audible sounds; some of the interaction between interviewer and participant might be lost when they cannot see each other (116). On the other hand, not being able to see one another can also create an atmosphere in which it is easier for the participant to share sensitive information and can thus be an advantage (127). Another advantage with telephone interviews is that they
are time-effective, which hopefully facilitated for the RNs to participate in the interview.

A semi-structured interview guide was used. The interview questions concerned the experience of attending the educational intervention in social insurance medicine, what was good and what could be improved, examples of when the participants had used their new knowledge in practice, and in what way the educational intervention had changed their way of working with sick leave questions.

Table 4. Characteristics of participants in Study IV.

<table>
<thead>
<tr>
<th>Primary health care centre number</th>
<th>Age</th>
<th>Experience of telephone nursing, years</th>
<th>Working hours in telephone nursing, %</th>
<th>Ownership primary health care centre</th>
<th>Education in social insurance medicine</th>
<th>Gender</th>
<th>Specialist nurse education</th>
<th>Employment</th>
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<tbody>
<tr>
<td>7</td>
<td>30</td>
<td>1-5</td>
<td>50-100</td>
<td>Public</td>
<td>No</td>
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<td>Full-time</td>
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<td>50-100</td>
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<tr>
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<td>Full-time</td>
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<td>32</td>
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<td>50-100</td>
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</tr>
<tr>
<td>2</td>
<td>30</td>
<td>1-5</td>
<td>50-100</td>
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<td>No</td>
<td>Male</td>
<td>Yes</td>
<td>Full-time</td>
</tr>
<tr>
<td>2</td>
<td>51</td>
<td>≥ 10</td>
<td>&lt; 50</td>
<td>Private</td>
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<td>Yes</td>
<td>Part-time</td>
</tr>
<tr>
<td>13</td>
<td>35</td>
<td>1-5</td>
<td>50-100</td>
<td>Public</td>
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<tr>
<td>8</td>
<td>65</td>
<td>≥ 10</td>
<td>50-100</td>
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<td>Female</td>
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<td>Full-time</td>
</tr>
<tr>
<td>8</td>
<td>60</td>
<td>≥ 10</td>
<td>50-100</td>
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<tr>
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<td>55</td>
<td>≥ 10</td>
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<td>No</td>
<td>Female</td>
<td>No</td>
<td>Part-time</td>
</tr>
</tbody>
</table>

Analysis

Study I: Giorgi’s phenomenological method

Giorgi’s phenomenological method (108, 113-115) inspired the analysis in Study I. Phenomenology as a scientific method exists in variants, and Giorgi’s method is among the descriptive phenomenological methods (109).

The Giorgi method includes taking on a phenomenological attitude. This is done through phenomenological reduction (bracketing); this includes bracketing one’s prior knowledge of the phenomenon, considering it as it is given, and describing it as it is intuited. The aim of bracketing is to prevent
pre-understanding from misleading the understanding of meaning (128, 129).

The act of bracketing is also described by Dahlberg (2006) as bridling (130). Dahlberg adds guidance to how the bridling act is to be pursued. The bridling act involves gently withholding one’s preconceived ideas of what the phenomenon looks like in order to ‘not make definite what is indefinite’ (p. 121 (111)). If the researcher can tolerate to bridle the understanding, with time, the essence and meaning will appear.

Taking on a phenomenological attitude in Study I meant that the first author, in the planning phase of the study, wrote down answers to the question ‘What do I think it means to be on long-term sick leave?’ It also included probing the meaning units, revelatory themes and main themes with the question ‘Is this what it means for this person/these persons to be on long-term sick leave?’ The analysis was a constant flow between going back to the interviews to confirm that the descriptions concurred with the original experiences and going forward, abstracting the experiences. This mainly occurred with the first author, but the research team also reflected together.

The phenomenological attitude further includes an attitude that is sensitive to the disciplinary perspective of the researcher, in this case the nursing perspective, and employing free imaginative variation to arrive at higher abstraction and more invariant essences (128, 129). Free imaginative variation was executed in an exploration of freely chancing aspects or parts of the revelatory themes, and themes to detect how the essence was structured (129), as described above.

The analysis followed the four steps of Giorgi’s analysis process:

1. Reading the data: all transcribed interviews were read several times to attain a sense of the whole and a sense of the constitution of the parts.
2. Breaking the data into parts: the text was divided into meaning units that described the experience of being on sick leave. The descriptions were put into a scheme.
3. Organizing the data: the meaning units were examined, probed and re-described in a more scientific language in ‘revelatory themes’.
4. Expressing the structure of the phenomenon: the essential revelatory themes, along with the main themes, were probed with the use of free imaginative variation, and an essential structure of the phenomenon emerged (Table 6).

Studies II and IV: Qualitative manifest content analysis

Studies II and IV were both analysed using qualitative manifest content analysis, described by Graneheim and Lundman (131). In manifest content
analysis the researcher analyses the content that is visible and obvious and does not interpret unspoken, underlying meanings, as is done in latent content analysis (131). It does, however, include some interpretive elements in the stage of forming themes (131).

First the transcribed interviews were read in order to attain a sense of the whole (familiarization). Meaning units consistent with the aim of the studies were searched and marked in the text. The meaning units were then condensed and coded, and similar codes were grouped into sub-categories and categories. The categories and sub-categories were checked against meaning units for concordance. Abstracted themes, (in Study III a theme) emerged, describing the underlying experiences running through the categories.

In Study II the three abstracted themes formed the RNs’ experiences of handling sick leave questions; see Table 5 for examples of the different stages of the analysis process.

As Study III had a twofold aim, two domains separated the experience of the intervention and the intervention’s perceived effect in terms of changes in handling sick leave questions (Table 10).
<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Condensation</th>
<th>Code</th>
<th>Sub-category</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>They’ve been home for a week and want a certificate. That’s who we’re most in contact with, you know it’s not these long-term sick leaves anymore but rather they’ve been home for a week and want to have a certificate for their employer. That’s who I think we’re the most in contact with.</td>
<td>They need to come in for a physician’s certificate after having been home for a week.</td>
<td>Assessment for sickness certification is needed after a week of self-certification</td>
<td>Assessment based on the rules of the social insurance</td>
<td>Make assessments for appropriate action</td>
<td></td>
</tr>
<tr>
<td>We’re actually supposed to do a medical evaluation, and I mean if it’s somebody with a regular cold who’s at home because they don’t have the energy, we have no obligation to have them come in because for us a normal cold isn’t a medical priority because it will go away on its own.</td>
<td>We’re to do a medical evaluation of the need of a physician’s appointment.</td>
<td>Medically based assessment of the need of an appointment</td>
<td>Assessment based on medical symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>And then that doctor had expressly written that it would be a follow-up appointment, even though it was one of these long-term sick-listed patients, and there weren’t any appointment times with the doctor today for that. So I had to change an appointment.</td>
<td>The physician had written that it would be a follow-up appointment.</td>
<td>Assessment based on documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I book the patient and then it’s up to the doctor to determine whether or not they should be sick-listed.</td>
<td>The registered nurse books appointments with physicians</td>
<td>Booking of appointment with the physician</td>
<td>Book appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>And some people, you know, ring when they’ve been home for 3-4 days… I need a sickness certificate because my sick leave ends in 3-4 days. Yeah but maybe you ought to wait till then and see how you feel? A lot can happen during those days.</td>
<td>The registered nurse provides information about the rules concerning social insurance.</td>
<td>Information-giving</td>
<td>Give information and guidance to the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I: Sometimes they, you know, ring back and say they don’t want to go, and then they want to get a second opinion from someone else. M: And what do you then? I: Yeeah…(sighs)… I send them back to the rehabilitation coordinator.</td>
<td>The registered nurse helps the patient when he/she wants a second opinion.</td>
<td>Help the patient</td>
<td>Monitor patients’ rights</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Study III: Nominal logistic regression

Three models of analysis were tested using nominal logistic regression and the outcome variable was ‘experienced problems with sick leave questions in telephone nursing at follow-up’. The outcome variable was a dichotomisation of the question ‘How often do you find it problematic to handle SLQs?’ Response alternatives were dichotomized into not experiencing problems (less than once a week) and experiencing problems (once a week or more often). Possible response alternatives were: ‘never’, ‘a few times a year’, ‘a few times a month’, ‘1–5 times a week’, ‘6–10 times a week’, and ‘more than 10 times a week’. In a previous study, two ways of dichotomizing the variable were tested and performed with approximately similar results (1).

In model 1 analyses were made with dependent variable were being intervention or control group and independent variables were ‘age at baseline’, ‘worked with telephone nursing ≥6 years’, ‘worked with telephone nursing ≥50% of working hours’, ‘workplace has a policy for handling sick leave’, ‘gets no support from managers’ (the five significant variables in Table 8) and ‘experienced problems with sick leave questions in telephone nursing at baseline’.

In model 2, nonsignificant exposure variables were backward eliminated. In model 3, a propensity score (based on all variables in Table 8 except for ‘experienced problems with sick leave questions in telephone nursing at baseline’ was used as exposure. The propensity score was obtained from the prediction option in the ‘SAS logistic’ procedure, which is a nominal regression analysis model using the randomized groups (intervention yes/no) as dependent variables and all risk-affecting variables as independent variables.

The Statistical Analysis System software package, version 9.3, was used for analyses. Missing values were on average 0.3% of the data, and were replaced with the means of observations with non-missing values in the corresponding variables. This was done to avoid the exclusion of randomized observations in the analyses.

All subjects were analysed based on ‘intention to treat’; that is, in the group they were randomized to, regardless of whether or not they had participated in the educational intervention and whether or not they had responded to the follow-up questionnaire. In the latter case, no change from the baseline questionnaire was assumed to have occurred.

The c index statistics, the agreement between predicted probabilities and observed responses, was high at 80-85%; thus, the precision of the analysis models was satisfactory. Two-tailed tests were used, and p-values less than 0.05 were considered to indicate significance.
Ethical considerations

All studies of this thesis followed the ethical principles for medical research involving human subjects in the Declaration of Helsinki (132) and the Swedish Act Concerning Ethical Review of Research Involving Humans (133). The participants were informed that participation was voluntary and that they could withdraw their participation at any time. Further, they were informed that their confidentiality would be protected through a coding of their identity. All participants signed consent at inclusion. Studies I, III and IV were approved by the Regional Research Ethics Board in Uppsala, Dnr 2011/131-31/5, Dnr 2014/156, and Study II by Mälardalen University.

Participants in Study I were patients on long-term sick leave in primary health care. Being ill and being a person in need of both medical care and benefits entail a dependence on authorities, and this means that the person is the party with less power. The participants were to tell about their experiences with the involved authorities, and may have perceived a risk in expressing negative experiences since these authorities influence their treatments and benefits. In an attempt to prevent any negative effects this might have on the interviews, the participants were informed that neither the authorities involved in their care nor those involved with their benefit approvals would know they were included in the study. Nor would their identity be revealed in the reporting of the study. The interviews were held at a neutral place, for example a library, and not at care facilities, in order to stress that the interviews were separate from their care.

Some special circumstances were taken into account: RNs in Studies II, III and IV worked in the county where the studies were held. Some might have been reluctant to talk about negative experiences, fearing their managers would hear of it. This was addressed by coding their identities and informing them that the results of the studies would only be presented on group level, as well as by engaging a researcher who had not been part of the educational intervention to interview the RNs in Study IV.
Findings

Study I: Experiences of being on sick leave

The essential meaning of being on sick leave was the *loss of independence*. Independence was lost when the persons on sick leave, due to illness, had to stop working and start relying on the state for support. The uncertain waiting to heal, the absence from work, and the conditions for support from the state caused processes that for most of them impaired their confidence in themselves and authorities.

The independence loss was connected to (main themes) *stepping out of working society*, *following the steps in the rehabilitation chain*, and the numerous encounters with professionals (Table 6).

Table 6. Analysis structure Study I.

<table>
<thead>
<tr>
<th>Revelatory theme</th>
<th>Main theme</th>
<th>Essence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting in uncertainty</td>
<td>Stepping out of working society</td>
<td></td>
</tr>
<tr>
<td>Changed self-perception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigmatization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changed economic conditions</td>
<td>Following the steps in the rehabilitation chain</td>
<td></td>
</tr>
<tr>
<td>Feelings of powerlessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being questioned</td>
<td>Numerous encounters with professionals</td>
<td></td>
</tr>
<tr>
<td>Getting mixed messages and sitting in-between</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disrespectful encounters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respectful encounters</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Stepping out of working society

The persons on sick leave were forced by illness to stop working and step out of the working society. Even though they wanted to work, they were not able to. For some the sick leave was a welcome time for rest and a relief
after having struggled for a long time, while for others it was enforced by professionals or urged by relatives.

For several of the persons, the initial time on sick leave was a blurred and unclear period, followed by waiting. The waiting caused stress and worry, because it was uncertain when it would end. Some of the persons on sick leave did not know what they were waiting for, while others were waiting for an appointment time with a specialist, or to recover. The unstructured weekdays caused inactivity, passivity, and even apathy. Some had positive experiences of part-time sick leave, as it meant more time for rest but at the same time a continuation of work.

Not being able to work but wanting to was described by some as generating feelings of being a second-class human or an incomplete human being. Work was very positive and important for their self-confidence and self-esteem, and not being at work changed their self-perception in a negative way. This is described below by one of the persons on sick leave:

Interviewer: Is that what feels like the most important thing, that you get some kind of help?

I1: Of course, so I can return to working life. It’s not so damned fun to be home, and I feel psychologically bad from it too.

Interviewer: You do? A lot of people say that. Is it the case that feel it’s, hard, how you feel? Perhaps you could describe how it feels when you feel that way, because it can express itself in various ways.

I1: I’m not worth anything, damn, you can’t do anything, you’re worthless as a person. (Interview 1)

The persons on sick leave described experiences of being questioned by both authorities and people in their immediate surroundings after being on sick leave. They also experienced stigmatization; people expected them to behave in a certain way and to have visible signs of illness when on sick leave. The feeling of shame was very strong for one of the women:

Interviewer: And what are you ashamed of?

I11: Yeah, you’re ashamed because you...because you sort of have...yeah, what are you ashamed of actually? I don’t know what I’m ashamed of...I’m ashamed because...very good question...(pause)...I’m ashamed because I’ve ended up where I have...I mean that I specifically – so happy and positive and strong, and having worked since I was like 14...yeah, I guess it’s that that’s...you’re ashamed because you don’t have the energy, you’re ashamed because you’re bored, you’re ashamed because you’re tired and worn out and you’re ashamed of most things actually. You’re ashamed because you’re not fun and...yeah...(pause) I’ve never thought about why I’m ashamed, that
was a good question. There’s a lot of shame…lots of feelings of shame that… (Interview 11)

Most of the participants’ economic conditions changed for the worse after being sick-listed. A consequence of this was that the persons on sick leave cut back on food, clothes and entertainment as well as heating, and used up all their savings. Some described that not being able to support their family caused feelings of worthlessness and shame. A few had no financial problems at all as they were supported by their partner or private insurance.

Following the steps in the rehabilitation chain

To be entitled to support and rehabilitation, the persons on sick leave were obliged to follow the steps in the rehabilitation chain. This was experienced as losing control and not having any influence, and evoked feelings of powerlessness: they would not get their allowance if they did not do as they were told.

Some wanted rehabilitation but were not offered it, and had to initiate and perform it themselves. Others were offered rehabilitation but did not perceive that it would help them. Some were accused of not wanting to get well when they did not want to participate in some of the rehabilitation measures.

The feelings of powerlessness also concerned suggestions for new types of work that would fit the person’s current work capacity, when the suggestions were incompatible with the person’s competence and wishes. Some described that it felt like it did not matter what they wanted or thought. For some, engaging in labour market measures was positive since it resulted in a new job.

Numerous encounters with professionals

Being on sick leave meant being exposed to, and forced to encounter, numerous professionals such as physicians, physiotherapists, and officers at the Swedish Social Insurance Agency, municipality, and the Public Employment Service. During these encounters, the persons on sick leave described being constantly questioned. Many described not being believed or listened to, and having their credibility questioned.

At reconciliation meetings, some of the persons on sick leave even experienced being in the middle of quarrels between authorities concerning their abilities. This felt meaningless and humiliating. One of the interviewed persons describes:

17:…but then the Social Insurance Agency and the Public Employment Service and the doctor got in a disagreement and I had to sit there like a fifth wheel it felt like…and like now you all need to stop this, you’ll have to do
this somewhere else, I shouldn’t have to sit and listen to this. So I got a physician’s certificate and I got it, like, on paper what the doctor thought about the Social Insurance Agency and the Public Employment Service; it was there on my physician’s certificate and I was like…you’re not doing as I’m asking, the Public Employment Service isn’t doing as I’m asking

Interviewer: Yeah err, did you have the opportunity to express what you wanted to…

I7: You just sat there crying…In my mind they were the ones doing the reasoning, you just sat there like a little speck of dirt on a chair…you weren’t, you know…you were just a name that, like…they, you know, talked about me the whole time…it was awful. (Interview 7)

The persons on sick leave also described being treated disrespectfully by professionals, with the disrespect manifesting itself in behaviour and language. Positive and respectful encounters were also part of their experiences:

Interviewer: Is there anything you’d like to add before we finish?

I15: Yeah, I guess it’s that I think I’ve been treated very very well in all stages…that’s something I wish more people could experience… (Interview 15)

A few described entirely positive encounters while some had both positive and negative experiences, but it was mainly negative experiences that were described in the interviews.

Study II: Registered nurses work with sick leave questions

The RNs described the everyday work of handling sick leave questions in telephone calls as firstly (categories) make an assessment for appropriate action, and secondly doing one or several of the following: book appointments, give information and guidance to the patient, and monitor patients’ rights (see Table 7 for an overview of themes and categories).

Registered nurses’ actions

_Making an assessment for appropriate action._ After receiving a telephone call, the RNs described making an assessment of appropriate action to take in order to address the question. Assessments were based on medical symptoms, social insurance rules, and/or on notes in the patient’s medical record. The patient’s described symptoms were taken into account if he/she wanted to have an appointment before the self-certification ended (seven days). So-
cial insurance rules were the basis for assessment when the patient requested a sickness certificate or the prolongation of a certificate. Notes in the patient’s medical record served as guidance when the patient had been sick-listed before and the treating physician had made a note or a plan regarding what to expect in the time ahead. For example, the note could describe whether the sick leave was expected to continue or be completed, or whether or not the physician wanted to see the patient at the clinic.

Table 7. Themes and categories in Study II.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Sub-category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses'</td>
<td>Make assessments for</td>
<td>Assessment based on rules of social insurance</td>
</tr>
<tr>
<td>actions</td>
<td>appropriate action</td>
<td>Assessment based on medical symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assessment based on documentation</td>
</tr>
<tr>
<td></td>
<td>Book appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Give information and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>guidance to the patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitor patients' rights</td>
<td></td>
</tr>
<tr>
<td>Enabling conditions</td>
<td>Documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Routines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supportive cooperation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training</td>
<td></td>
</tr>
<tr>
<td>Obstructing conditions</td>
<td>Patients' expectations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problematic cooperation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulties related to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the registered nurses'</td>
<td></td>
</tr>
<tr>
<td></td>
<td>professional role</td>
<td></td>
</tr>
</tbody>
</table>

Booking appointments. The appointments could be with the physician, but also other professionals such as physiotherapists or district nurses. The RNs described that callers often specifically wanted a physician appointment. Guiding the patient to the right level of care, which was not always a physician, was part of the job. For example, a patient with back pain could be referred directly to a physiotherapist for treatment instead of seeing the physician first.
Giving information and guidance to the patient was described by the RNs as including giving information on social insurance rules. This task was described as part of the role as a telephone nurse:

...our area of responsibility is the informative part – I think so, anyway – and if we don’t have [information] we lose that, and then there’s a decline in our profession when you think about where we are (Focus group A).

The RNs expressed different views on their role in the work with sick leave questions by telephone. Some described the parts above, while others expressed that it was not their responsibility to deal with sick leave and saw their role as that of an appointment booker.

Monitoring patients’ rights could involve helping dissatisfied patients, facilitating contact with other authorities, or delivering information to the physician, the rehabilitation team, or the Swedish Social Insurance Agency:

RN: The patient felt very offended, because he felt that the Social Insurance Agency had received information it shouldn’t have.

Moderator: And how did you handle that?

RN: talked with the patient and talked with the doctor and talked with the Social Insurance Agency, and the patient also got to talk with the doctor. (Focus group C)

Enabling conditions

Enabling conditions for the work with sick leave questions in telephone calls were described by the RNs to be (categories): notes in medical record, routines, cooperation and training.

Notes in the patient’s medical record were highly useful when he/she requested an extension of an already existing sickness certificate. It was difficult to know what to do if the physician had not documented a plan for the expected development of the sick leave.

Routines for sick leave at the primary health care centre were experienced as enabling for a well-functioning sick leave process. Retroactive sick-listing was mentioned as one area in which routines were especially facilitative.

Supportive cooperation with other professionals at the primary health care centre was experienced as helpful when it was difficult to assess appropriate
measures. In such cases the RNs asked the rehabilitation coordinator, their peers, or physicians for advice on what to do. RNs also described that, after the rehabilitation coordinators were introduced as being responsible for monitoring patients on long-term sick leave, things got much easier since they could then turn to this person when they were unsure of what to do.

*Training* was also something that was experienced helpful for the work. Some of the RNs told that they had specific training in social insurance medicine but it was not common.

**Obstructing conditions**

Obstructing conditions for the work were (categories): *patients’ expectations, problematic cooperation, lack of training, and difficulties related to the RNs’ professional role.*

*Patients’ expectations* were sometimes not in line with the social insurance rules. Patients expected to have a sickness certificate if they had ‘untenable home conditions’, ‘tiredness due to having an infant’, ‘tiredness due to work’, ‘work problems’, ‘divorce’, or ‘trouble with teenage children’. RNs felt this was difficult to handle.

*Problematic cooperation* was sometimes an obstruction in the work. Physicians often had different wishes for how their patients on sick leave should be handled, with some wanting them to have an appointment booked every time they called and others wanting a telephone time to be booked with the patient. If there were routines, they did not seem to apply to physicians:

> It also depends a bit on which doctor it is who’s handling the problem, I mean each doctor is so different in the way they think, and when you’ve worked for a long time you start to nearly know how they think. But then, when new doctors come in, you don’t know and then there are problems again. Some of them are…quite…clear about what it is they do, even in their notes in the patient’s medical records, but that happens more seldom than often. (Focus group A)

The RNs also expressed a wish for more communication and feedback from other professionals regarding appointments they had made, in order to know if they had made the right assessments in the telephone calls. The RNs did not have the time to follow-up on the calls, and this made them feel as if they were not part of the process.

*Lack of training* made it problematic for the RNs to deliver information to patients as they did not know what to say. Some of the RNs had attended in-
house information meetings about changes in social insurance rules and/or guidelines. They described the rules/guidelines as difficult to grasp, and as ‘one thing too many to have in your head’. They wanted more education and training in order to be able to make better assessments.

**Difficulties related to the professional role.** When there was a lack of appointment times, the RNs expressed feeling split between the patient’s need for an appointment and the lack of organizational resources. The demands contradicted each other. This caused stress, and the RNs described that it was very hard job to have the task of being a ‘gatekeeper’ for the available appointment times at the primary health care centre:

RN 1:…it’s a really hard job when we have to sit there and deny everybody who doesn’t, who we think should perhaps come in but isn’t allowed to come in. But most often it’s the lack of appointment times that’s the trickiest thing.

RN 2: Before it was really, really difficult on the telephone but now it’s good, it’s so easy for them to reach us, the patients are happier and we’re not fussed at on the telephone as much anymore, but like I said it’s hard because there still aren’t enough appointment times, it’s really hard to do evaluations sometimes, you’re like, sometimes you go home and worry you’ve said the wrong thing or something. (Focus group C)

The RNs also had to handle dissatisfied patients when the physician and patient had differing opinions about certificates. This felt like ‘being in the firing line’ and was very hard to handle. Some took help from other professionals in order to solve this, while others did not bother arguing with either the physician or the patient and simply booked an appointment with the same or another physician.

**Study III: The effect of the educational intervention**

There were 59 eligible RNs in the intervention group, of which 28 participated, 28 declined due to unknown reasons, and three participated in only one of the sessions (Table 8). The intervention group and the control group differed on a number of variables, some of them favouring the intervention group and others the control group. When these differences were collected in a propensity score measure, the score was 0.75 (SD 0.24) in the intervention group and 0.35 (SD 0.25) in the control group. This difference was taken into account in the analysis.

The odds ratio of outcome in the intervention group compared to the control group was 0.49 (p=0.27) with a degree of explanation of 84% in model 1 (Table 9, see Appendix 2 for crude odds ratios). In model 2 odds ratio was 0.61 (p=0.35), degree of explanation 80%, and in model 3
odds ratio was 0.32 (p=0.11), degree of explanation 84%. The odd ratio of model 3 indicates that the intervention group experienced 68% fewer problems in handling sick leave questions than the control group. However, the odds ratio was not conclusive: p=0.11.

A post-hoc statistical power analysis based on the findings of the study showed that 123 participants would be required for a significant result (with an 80% power). The statistical power of the present study with its 100 participants was calculated to 71%.
Table 8. Baseline characteristics of the study population in Study III

<table>
<thead>
<tr>
<th></th>
<th>Intervention group, n (%)</th>
<th>Control group, n (%)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean (SD) or %</td>
<td>n</td>
</tr>
<tr>
<td>N</td>
<td>59</td>
<td>100</td>
<td>41</td>
</tr>
<tr>
<td>Age, years</td>
<td>50.6 (10.3)</td>
<td>45.5 (9.7)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Women, %</td>
<td>56</td>
<td>94.9</td>
<td>41</td>
</tr>
<tr>
<td>Participated in educational intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both educational sessions, %</td>
<td>28</td>
<td>47.5</td>
<td>0</td>
</tr>
<tr>
<td>One educational session only, %</td>
<td>3</td>
<td>5.1</td>
<td>0</td>
</tr>
<tr>
<td>Has a specialist nursing degree, %</td>
<td>46</td>
<td>78.0</td>
<td>26</td>
</tr>
<tr>
<td>Has worked with telephone nursing ≥6 years, %</td>
<td>38</td>
<td>64.4</td>
<td>19</td>
</tr>
<tr>
<td>Worked in county council-operated primary health care centre, %</td>
<td>46</td>
<td>78.0</td>
<td>37</td>
</tr>
<tr>
<td>Working full-time, %</td>
<td>35</td>
<td>59.3</td>
<td>26</td>
</tr>
<tr>
<td>Telephone nursing ≥50% of working hours, %</td>
<td>42</td>
<td>71.2</td>
<td>19</td>
</tr>
<tr>
<td>Own sick leave &gt;7 days during last 5 years, %</td>
<td>31</td>
<td>52.5</td>
<td>19</td>
</tr>
<tr>
<td>Workplace policy for handling sick leave, %</td>
<td>29</td>
<td>49.2</td>
<td>33</td>
</tr>
<tr>
<td>Handling sick leave questions is not a work environmental problem for me, %</td>
<td>23</td>
<td>39.0</td>
<td>18</td>
</tr>
<tr>
<td>Gets no support from managers, %</td>
<td>12</td>
<td>20.3</td>
<td>2</td>
</tr>
<tr>
<td>Has a role in health care of patients on sick leave, %</td>
<td>40</td>
<td>67.8</td>
<td>28</td>
</tr>
<tr>
<td>Educated in social insurance medicine, %</td>
<td>2</td>
<td>3.4</td>
<td>1</td>
</tr>
<tr>
<td>Telephone calls with sick leave questions once a week or more often, %</td>
<td>53</td>
<td>89.8</td>
<td>39</td>
</tr>
<tr>
<td>Measures in telephone calls with sick leave questions taken often or always</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making physician telephone appointments, %</td>
<td>21</td>
<td>35.6</td>
<td>22</td>
</tr>
<tr>
<td>Solving problems, %</td>
<td>15</td>
<td>25.4</td>
<td>6</td>
</tr>
<tr>
<td>Referral to other staff, %</td>
<td>3</td>
<td>5.1</td>
<td>6</td>
</tr>
<tr>
<td>Other measures, %</td>
<td>4</td>
<td>6.8</td>
<td>4</td>
</tr>
<tr>
<td>Providing information, %</td>
<td>2</td>
<td>3.4</td>
<td>2</td>
</tr>
<tr>
<td>Experienced problems with sick leave questions in telephone nursing at baseline, %</td>
<td>35</td>
<td>59.3</td>
<td>32</td>
</tr>
<tr>
<td>Experienced problems with sick leave questions in telephone nursing at end of follow-up, %</td>
<td>34</td>
<td>57.6</td>
<td>31</td>
</tr>
</tbody>
</table>
Table 9. Results of the randomised controlled trial on outcome (the effects on experienced problems with sick leave questions in telephone nursing) according to ‘Per protocol’ analysis strategy according to the three analytical models.

<table>
<thead>
<tr>
<th>Model</th>
<th>Exposure</th>
<th>Estimate (SE)</th>
<th>Wald’s χ²-square</th>
<th>Degree of explanation</th>
<th>Odds ratio</th>
<th>95% confidence interval</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full model (model 1)</td>
<td>Intervention vs. control group</td>
<td>-0.7052 (0.64)</td>
<td>1.20</td>
<td>84 %</td>
<td>0.49</td>
<td>0.14-1.74</td>
<td>0.27</td>
</tr>
<tr>
<td></td>
<td>Age at baseline</td>
<td>-0.0362 (0.03)</td>
<td>1.38</td>
<td>96 %</td>
<td>0.96</td>
<td>0.91-1.03</td>
<td>0.24</td>
</tr>
<tr>
<td></td>
<td>Has worked with telephone nursing ≥6 years</td>
<td>0.6260 (0.35)</td>
<td>3.13</td>
<td>87 %</td>
<td>1.87</td>
<td>0.94-3.74</td>
<td>0.08</td>
</tr>
<tr>
<td></td>
<td>Telephone nursing ≥50% of working hours</td>
<td>-0.1646 (0.57)</td>
<td>0.08</td>
<td>85 %</td>
<td>0.85</td>
<td>0.28-2.57</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Work place policy for handling sick leave</td>
<td>-0.4768 (0.95)</td>
<td>0.25</td>
<td>62 %</td>
<td>0.62</td>
<td>0.10-4.00</td>
<td>0.62</td>
</tr>
<tr>
<td></td>
<td>Gets no support from managers</td>
<td>-0.3123 (0.45)</td>
<td>0.49</td>
<td>73 %</td>
<td>0.73</td>
<td>0.31-1.76</td>
<td>0.49</td>
</tr>
<tr>
<td>Full model with backward elimination (model 2)</td>
<td>Intervention vs. control group</td>
<td>-0.4992 (0.53)</td>
<td>0.89</td>
<td>80 %</td>
<td>0.61</td>
<td>0.22-1.71</td>
<td>0.35</td>
</tr>
<tr>
<td></td>
<td>Experienced problems with sick leave questions at baseline</td>
<td>2.5375 (0.52)</td>
<td>24.22</td>
<td>12.65</td>
<td>4.60-34.75</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>Model with propensity score (model 3)</td>
<td>Intervention vs. control group</td>
<td>-1.1395 (0.71)</td>
<td>2.6</td>
<td>84 %</td>
<td>0.32</td>
<td>0.08-1.28</td>
<td>0.11</td>
</tr>
<tr>
<td></td>
<td>Experienced problems with sick leave questions at baseline</td>
<td>2.6900 (0.55)</td>
<td>24.33</td>
<td>14.73</td>
<td>5.06-42.90</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Propensity score</td>
<td>1.6022 (1.15)</td>
<td>1.94</td>
<td>4.96</td>
<td>0.52-47.24</td>
<td>0.16</td>
<td></td>
</tr>
</tbody>
</table>
Study IV: The experience of the educational intervention

The main finding, the theme (Table 10) that emerged from the RNs’ descriptions, was that they had gained role clarity in their work with sick leave questions.

The findings are presented in two domains: experience of the intervention and experience of changes in handling sick leave questions, with adherent sub-categories and categories.

Table 10. Analysis structure in Study IV.

<table>
<thead>
<tr>
<th>Sub-category</th>
<th>Category</th>
<th>Theme</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaining knowledge of rules and regulations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gaining knowledge of actors’ different roles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gaining knowledge of the patient’s perspective of sick leave</td>
<td>Gaining role clarity of the sick leave process</td>
<td>Experience of the intervention</td>
<td></td>
</tr>
<tr>
<td>Learning from peers in group discussions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning by reflecting and asking questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowing what to say and do</td>
<td>Having skills to handle sick leave questions</td>
<td>Experience of changes in handling sick leave questions</td>
<td></td>
</tr>
<tr>
<td>Knowing where to turn for support</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Experience of the intervention

The domain experience of the intervention was described as the category gaining knowledge of the sick leave process, with sub-categories gaining knowledge of rules and regulations, gaining knowledge of the patient’s perspective of sick leave, learning from peers in group discussions, and learning by reflection and asking questions.
Gaining knowledge of the sick leave process

This category includes the participating RNs' descriptions of increasing their knowledge of social insurance medicine and the sick leave process. The experience of participating in the intervention was foremost described as gaining knowledge. This knowledge had been lacking before the intervention, and would have been useful to have before. While most of the RNs were positive about participation, some criticism was voiced regarding the shortness of the educational intervention time, and the fact that personnel from other professions at the primary health care centres were not included as participants. One RN described initially seeing participation as a waste of time. However, she had changed her mind after participating, and described that the knowledge she had gained had been very useful in her current work:

When I received that, that I was going to attend the educational intervention I thought: ‘God, how boring, what a waste of time’. [laughs] But then when I was there I thought it was really good, I thought it really offered a lot. First of all, all these...different names, you’re sick-listed, on parental leave, you’re on a disability pension…there’s so much. And that was something I had no idea about before. (Interview 2)

The experience of gaining more knowledge was described in five areas (sub-categories): gaining knowledge of rules and regulations; gaining knowledge of actors' different roles; gaining knowledge of the patient's perspective of sick leave; learning from peers in group discussions; and learning by reflecting and asking questions.

Gaining knowledge of rules and regulations The intervention gave knowledge about the Swedish social insurance rules and different time limits attached to the sick leave process (Swe. Rehabiliteringskedjan). Before the intervention, this knowledge had been either unknown or too difficult to comprehend.

Gaining knowledge of actors' different roles The RNs described that the knowledge of actors’ different roles gave them an understanding of why there are sometimes problems connected to sick leave and sickness certificates. Knowledge of the physician’s role and responsibility when issuing a sickness certificate, as well as the role and responsibility of the Swedish Social Insurance Agency, was described as especially useful.

RNs described that, now that they understood this, this they could better handle issues such as demands from the Swedish Social Insurance Agency for clarification of a sickness certificate. The knowledge also helped them understand why patients call to get help with an incomplete sickness certificate.
Gaining knowledge of the patient’s perspective of sick leave
Some RNs described gaining a deepened understanding of the patient’s perspective of being on sick leave, especially their vulnerability. One RN described that by attending the educational intervention she had changed her preconceived idea that everyone on sick leave wanted to be at home:

I8: I hadn’t grasped that this area was so big. You perhaps have a greater understanding of people who ring, that’s what I’d say.

Interviewer: In what way did you get this?

I8: One of the educators explained a whole lot about how it was for people, that it might not be the case that they always want to be sick-listed. You can get this picture that people just want to be at home, but that’s not true. You have a slightly different way of thinking now, I believe. (Interview 8)

Learning from peers in group discussions Having the opportunity to take part in group discussions during the two educational intervention sessions was described as enhancing learning with the RNs. It was a positive experience to hear about other workplaces’ routines and the solutions to problems connected to sick leave.

Learning by reflecting and asking questions Some of the RNs described learning through the reflection assignment at Session 2, when they had the opportunity to discuss unsolved problems with both the course leaders and other participants. Being able to pose questions to the course leaders also enhanced learning. Some RNs described having had the opportunity to do the reflection assignment together with other professionals at their workplace and discuss local routines with them while doing the assignment. This was experienced as having a positive influence on the work, as it helped them know how to handle certain questions later on.

Experience of changes in handling sick leave questions
The domain Experiences of the intervention was described with the category Having skills to handle sick leave questions and the sub-categories Knowing what to say and do and Knowing where to turn for support.

Having skills to handle sick leave questions
As results from having participated in the educational intervention, the RNs described some changes in handling sick leave questions but also a change in their mind-set due to now having the skills needed to handle sick leave questions. The changes are described in the sub-categories knowing what to say and do and knowing where to turn for support.
Knowing what to say and do The most prominent change was described as a change in the communication with callers. This was due to now knowing what to say and do in the telephone calls. The RNs described that, as they now knew to a higher extent what to say and do, the handling of sick leave questions was easier and faster. This created a feeling of comfort and confidence in their role as telephone nurses. They also described that being able to resolve problems and help the patient increased their job satisfaction. A change in handling questions that was described was that of being more attentive to the risk factors connected to long-term sick leave. Another was that of being more coaching and encouraging towards patients trying out a previously discussed part-time sick leave. An RN describes the feeling of being more secure in her role:

I2: If you’re sick you’re sick, you’re not going to be excluded from social insurance. There are always exceptions.

Interviewer: Could you answer that in another way?

I2: Yes, I feel more sure that it’s not the case that you’ll be excluded from social insurance, but rather if you’re not healthy...because a lot is being written about this. It’s general, that I feel more sure, of the questions. Sure of the answers. (Interview 2)

Knowing where to turn for support After the intervention, RNs described that if they did not know how to handle a sick leave question they now knew where to turn for support. One RN described that in the past she had always booked an appointment with the physician but now she instead tried to solve some of the questions with the patient him/herself, for example by discussing matters with the physician or rehabilitation coordinator. Others described that it saved time to know where to turn for help:

I3: Maybe I don’t do things differently...but I get a lot of help from it now, being able to evaluate in the right way and not go backwards and forwards as much, because now I know I can go to the rehab coordinator and can go to the doctor and put a person on the waiting list, because then I know what that entails and I also try to explain it so the patient understands and accepts what I’m saying.

Interviewer: So you have the patient more with you than before?

I3: Yes, I think so. (Interview 3)
Discussion

Main findings
The overall aim of this thesis was to explore experiences of being on sick leave, to explore RNs’ role in the care of patients on sick leave and to explore the effect and experience of an educational intervention in social insurance medicine with RNs.

The thesis has produced several important findings. Among them are, firstly, that the essential meaning of being on long-term sick leave was a loss of independence. Independence was lost when the persons, due to illness, had to stop working and start relying on the state for support. The uncertain waiting to heal, the absence from work, and the conditions for support from the state caused processes that, for most of the interviewed persons, impaired their confidence in themselves as well as authorities.

The descriptions of what RNs do when handling sick leave questions, as well as conditions that facilitate or obstruct this work, are other important findings. They portray RNs as having a role as a professional actor in the sick leave process that takes place at primary health care centres in Sweden. The RNs described contradicting demands from patients and co-workers and a lack of organizational resources, as stressful. There were differences in the RNs’ understanding of their role in relation to sick leave questions. Some saw themselves as appointment bookers, while others saw their role as more diversified and corresponding with how other questions are handled in telephone nursing.

The performed short intervention seems to have had a strong effect on the experience of problems with sick leave questions in telephone nursing. However, the effect was inconclusive and needs further examination in larger samples. In the performed evaluation interviews, it was concluded that the intervention had increased the RNs’ knowledge and skills for handling sick leave questions. This had resulted foremost in the RNs describing that they now knew what to say and do when handling the calls. It was interpreted that the intervention had allowed them to gain role clarity in their work with sick leave questions in telephone nursing.
Experiences of being on sick leave

The essence of being on long-term sick leave was a loss of independence. This loss was linked to stepping out of the working society and following the steps in the rehabilitation chain, as well as to numerous encounters with professionals.

The interviewed persons’ loss of independence was described as being linked to three different areas in life: work (stepping out of working society), social insurance policy (following the steps in the rehabilitation chain), and encounters with professionals. This illuminates and confirms the importance of approaching sick leave with a perspective that includes all parts of life, a lifeworld perspective. If the study had solely explored encounters with health care, for example, the findings would likely not have shown that there are many other aspects outside health care that create the meaning of being on sick leave for the person.

Stopping working brought many changes to the persons’ life. The waiting, which was often uncertain, seemed to be especially stressful. The uncertainty came from not knowing when they would get well, and also often from not knowing what they were waiting for. In a study by Lindbäck and Nordgren (2015) of persons on sick leave due to heart failure it was also found that the sick leave was characterised by uncertainty, insecurity and also anxiety (35). Jansson and Björklund (29) also found that the waiting in the process was experienced as destructive when on long-term sick leave. This waiting most likely contributed to the experience of powerlessness, and seems to be important to address as a way to support persons on sick leave.

Many of the things the participants waited for could perhaps be made smoother and faster through improvements to the health care. Shortening waiting times, giving information on what to do to heal faster, and giving information about what to expect in the time ahead could be things that might help the patient. A well-informed patient would probably not feel as stressed about these things and may feel more in control.

No longer being able to work and support themselves was described by the persons on sick leave as changing their self-perception in a negative way, and also as negatively influencing their economy. Lowered self-image and lowered self-efficacy have been described in previous research on sick leave (10, 23, 25, 29-31, 134-137). Thus, the need for supportive actions concerning the psychological consequences of being on sick leave seems of great importance. Psychological support for handling the changes that accompany illness and sick leave, to my knowledge, is not routinely offered to all persons on long-term sick leave. This is a potential area of improvement in health care.

A feeling of stigma and shame because of being on sick leave was also described. Social norms and the behaviour of both others in society and professionals seemed to reinforce these feelings. This is seen in studies of recip-
ients of allowances as well as in negative encounters with professionals (30, 40, 137-140). Again, there is a need for psychological support for handling the experiences that accompany being on sick leave.

Experiences of losing independence also seem to be linked to a feeling of losing control and of not being able to choose what one’s ‘way’ through the system should look like. This caused feelings of powerlessness. The participants had to follow the steps in the rehabilitation chain to meet the demands for the allowance. The numerous encounters with professionals and continuous evaluations of their health and right to allowance also contributed to their feelings of powerlessness. Additionally, there were many descriptions of disrespectful encounters and of receiving mixed messages. Taken together, the present findings indicate that the demands for respectful treatment, participation, influence and person-centeredness set in the Health and Medical Services Act (51), Patient Act (49) and criteria of good-quality care (53) are not fulfilled for these patients.

Together, these findings indicate that there is great potential for improvement in the sick leave process concerning the experiences of persons on sick leave. Involving RNs to a greater extent in the sick leave process would likely mean increasing person-centeredness in the process, as this is one of RNs’ core competencies.

Registered nurses’ role in the care of patients on sick leave

Registered nurses’ work with sick leave questions was described as including the assessment of appropriate measures, appointment booking, information provision and/or guiding patients and monitoring their rights. These descriptions greatly coincide with previous research describing the contents of telephone nursing as: collecting information; assessing care need; making decisions; giving advice, support and education; referring to the right level of care; giving health care information; and coordinating care (77, 87, 141).

Comparing the present study’s findings to Greenberg’s main phases of the telephone nursing process – gathering information, cognitive processing, and output (87) – the present findings also have many corresponding parts (see Table 11). However, the interviewed RNs did not explicitly discuss Phase 1 but described that the assessment (corresponding to Phase 2) was based on medical symptoms and/or social insurance rules and/or notes in the patient’s medical record. Both the patient’s medical symptoms and notes in their medical record are information that needs to be collected by the RNs, and can be interpreted as corresponding to Greenberg’s Phase 1.
Table 11. Greenberg’s model of the process of telephone nursing in relation to findings in Study II.

<table>
<thead>
<tr>
<th>Greenberg’s model</th>
<th>Registered nurses’ actions when handling sick leave questions in telephone nursing (findings in Study II)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: Gathering Information</td>
<td>Medical symptoms</td>
</tr>
<tr>
<td>Getting started</td>
<td>Notes in the patient’s medical record</td>
</tr>
<tr>
<td>Information-seeking</td>
<td></td>
</tr>
<tr>
<td>Secondary gathering</td>
<td></td>
</tr>
<tr>
<td>Phase 2: Cognitive Processing</td>
<td>Making assessment of appropriate action</td>
</tr>
<tr>
<td>Determining</td>
<td></td>
</tr>
<tr>
<td>Decision-making</td>
<td></td>
</tr>
<tr>
<td>Planning</td>
<td></td>
</tr>
<tr>
<td>Phase 3: Output</td>
<td>Booking appointments</td>
</tr>
<tr>
<td>Disposition</td>
<td>Giving information and guidance</td>
</tr>
<tr>
<td>Supporting</td>
<td>Monitoring patients’ rights</td>
</tr>
<tr>
<td>Collaborating</td>
<td></td>
</tr>
<tr>
<td>Closing the call</td>
<td></td>
</tr>
</tbody>
</table>

Thus, the findings in Study I correspond to the standard phases of working in telephone nursing described by Greenberg. However, some of the RNs expressed that it was not their problem to deal with sick leave questions, and seemed to see themselves as merely appointment bookers. They described a way of working mainly targeted at booking an appointment with a physician, disclaiming responsibility for sick leave questions. Other RNs described a more problem-solving approach whereby different alternatives to a physician appointment were explored, for example giving information or cooperating with rehabilitation coordinator.

These findings suggest that there are different understandings of what RNs believe is included in the work of handling telephone calls with sick leave questions.

One reason for not adopting the common approach could be that an RN lacks education and opportunities for competence development. The RNs described this as obstructing the work with sick leave questions. Previous studies with physicians (120) and the one previous study with RNs (72) confirm a lack of education in social insurance medicine among professionals. These findings, together with the present findings, endorse that there is a need of competence development among professionals working with sick leave, as is suggested in the national guidelines for sick leave (54). To our knowledge, social insurance medicine is not included in the education of RNs, in either the basic or specialist education. It also does not seem as
though primary health care centres provide in-house training regularly. Thus, a need for educational interventions is obvious.

Another explanation for adopting different approaches to the work with sick leave questions can be found in role theory. Role theory describes that behaviour in work is guided by one’s role identity. Role identity is formed by how a person constructs the meaning and character of their role based on the behavioural expectations attached to that role (75). Thus, if we apply a role theory explanation to the present findings, it seems as if RNs form different role identities in relation to the work with sick leave questions. How the role identities have been formed by the present RNs, or what sort of expectations/behaviours they connect to this work, has not been explored. However, some described experiencing contradictory demands, which was hard to handle. There seems to be a need to address how RNs form their role identity in order to achieve a higher-quality care.

That work with telephone nursing can be understood in different ways has previously been found by Kaminsky, Rosenqvist and Holmström (88). Similar findings have also been found concerning other professionals in health care (142, 143). Kaminsky, Rosenqvist and Holmström (88) found that telephone nursing work was understood by the telephone nurses in five different ways. Some of them described only one of the ways of understanding their work, some several, and some all.

There may be unwanted effects if RNs do not have the same view of their role. It will probably affect the measures they take; i.e., the care they deliver. It would also affect other professionals at the primary health care centre, since the measures RNs perform are often a part of a chain of events. Rutenberg and Greenberg (90) describe that all initial training in telephone nursing should include the purpose of and standards for the work, but also discussion so that the goals are understood and shared by the organization at large. Addressing the understanding of the work needs to be part of the workplace introduction of new employees, but should also be included in continuous development. Preferably, as Rutenberg and Greenberg point out, these discussions should occur in interprofessional teams as the work in primary health care is built on the idea of teamwork as a way of optimally addressing a patient’s need, thanks to competence in different areas of knowledge.

Another important finding is the experience of contradictory demands causing stress for the RNs. They described experiencing a ‘gatekeeping’ role for available appointment times at the centre. When there was a shortage of appointment times and a patient needed an appointment, it was difficult to handle. The contradictory demands of patients in need and the lack of organizational resources were stressful. This position of having power and control of the entire centre in a ‘gatekeeping’ role and at the same time being a carer for the patient is described in previous studies of telephone nursing (90, 92,
Thus, this experience is not specific to handling sick leave questions but to telephone nursing from a general point of view.

However, studies with physicians and other professionals in connection to work with sick leave also describe the experience of contradictory demands. Studies with physicians report experiences of problems of having dual roles as both the patient’s carer and a medical expert when issuing sickness certificates (59-63). Social insurance officers also describe experiences of contradictory demands (144). Thus, this problem is previously known, and has been shown to be linked to the experience of work environmental problems among physicians (64), and should be addressed to improve professionals’ working environment.

When summarizing conditions surrounding telephone calls with sick leave questions, it can be established that RNs have many, sometimes contradictory, demands to consider when making assessments and taking measures. As previously described, telephone nursing is framed by factors such as state laws, county council guidelines and local routines, RN competence and ethics, organizational conditions, and conditions/relations to cooperating professionals. All these framing factors together form expectations of what role RNs should have in the work. However, there is not just one role and one set of expectations to adapt to. The role of telephone nurse includes multiple roles and multiple expectations, depending on the questions. The demands are high, and when time pressure is added to this it can easily be understood that stress can occur among RNs. These factors together are a possible explanation for why some RNs evade responsibility for tasks (e.g. handling sick leave questions) they do not have the competence to handle.

Registered nurses’ possibility to support patients on sick leave in telephone nursing

Comparing findings of the focus group discussions in Study II with RNs and the interviews with patients in Study I, it can be identified that RNs could possibly, with the right intervention, facilitate the sick leave process for patients to a higher extent than today, in the encounter in telephone calls (see Table 12). Firstly and fundamentally, RNs could possibly affect the patient’s experience by applying nursing values (21) in providing an encounter that corresponds to respect for human vulnerability, dignity, integrity, and autonomy. The described negative encounters with professionals highlight the importance of encounters that do not offend but rather encourage patients.

Other measures that RNs could do to possibly enhance the experiences of patients on long-term sick leave are identified to be mainly supportive and collaborative. A study by Olsson et al. (145) including 5,800 persons on long-term sick leave in Sweden confirms that having supportive and encour-
aging health care and social security staff was experienced to promote their ability to return to work.

Supportive actions that RNs could take in telephone calls could help reduce the described feelings of stressful waiting and powerlessness. Such an easy thing as finding out and explaining what the patient is waiting for and why, and possibly shortening the wait by collaborating with other actors, units or professionals, could perhaps be of help.

Including lifeworld dimensions (1, 111) in the supportive actions may also be beneficial. This could be done by being sensitive to, and asking the patient, what is important for them to live as well as possible despite the present circumstances. This could entail asking the patient how they are doing, asking about their mental health, exercise and food, or providing access to a suitable professional if a need of support from other professionals is identified. This way, the RNs could acknowledge that sick leave is a process that affects the whole life situation and that care offers many different ways to meet the needs that arise. RNs are trained to do similar work involving assessing needs based on a patient’s whole life situation not only when meeting them in clinics but also when making other assessments and providing care in telephone calls. This ‘detector’-like role in telephone nursing has previously been described as being a detective, searching for signs to solve the puzzle of why the patient is seeking care, and taking action to help the patient (88). This could also be applied to telephone calls with sick leave questions. If RNs get an education and competence development in, for example, identifying risk factors for long-term sick leave, they could work as detectors of these signs and serve as signallers of early signs of being at risk of long-term sick leave. This could enable patients to get help quickly, which is preferable for avoiding long-term sick leave (146).

Helping the patient regain power and enable a smoother process is also consistent with the demands of the Patient Law and the nursing community regarding person-centred care (17, 49). Telephone nursing, based on RN ethics whereby RNs identify and advocate for patient values and needs, could be a step towards developing the sick leave process to being more person-centred. Thus, RNs could be of great value to the development of the sick leave process.
Table 12. Persons’ experiences of being on long term sick leave (findings in Study I) and possible supportive actions (found in Greenberg’s model and Study II) that could affect the patients’ experience.

<table>
<thead>
<tr>
<th>Study I Main theme</th>
<th>Study I Revelatory theme</th>
<th>Possible supportive actions by registered nurses’ from Greenberg’s model</th>
<th>Possible supportive actions by registered nurses’ from findings in Study II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stepping out of the working society</td>
<td>Rest</td>
<td>Supporting Collaborating</td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
<tr>
<td></td>
<td>Waiting in uncertainty</td>
<td>Supporting Collaborating</td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
<tr>
<td></td>
<td>Changed self-perception</td>
<td>Supporting Collaborating</td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
<tr>
<td></td>
<td>Stigmatization</td>
<td>Supporting Collaborating</td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
<tr>
<td></td>
<td>Changed economic conditions</td>
<td></td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
<tr>
<td>Following the steps in the rehabilitation chain</td>
<td>Feelings of powerlessness</td>
<td>Supporting Collaborating</td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
<tr>
<td>Numerous encounters with professionals</td>
<td>Being questioned</td>
<td>Supporting Collaborating</td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
<tr>
<td></td>
<td>Getting mixed messages and sitting in-between</td>
<td>Supporting Collaborating</td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
<tr>
<td></td>
<td>Disrespectful encounters</td>
<td>Supporting Collaborating</td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
<tr>
<td></td>
<td>Respectful encounters</td>
<td>Supporting Collaborating</td>
<td>Giving information and guidance Monitoring patients’ rights</td>
</tr>
</tbody>
</table>
Educating registered nurses in social insurance medicine

The analysis of the effect of the educational intervention was inconclusive regarding experiencing fewer problems. Despite this, however, the strong association indicates that if the sample had been larger it might have been conclusive.

As, to our knowledge, no previous randomized controlled trials in social insurance medicine exist, comparisons of results to other studies are not possible. There is one qualitative descriptive interview study of RNs who participated in an educational intervention similar to the present intervention in social insurance medicine in Sweden (72). The findings in this study by Müssener and Linderoth include an experience of usefulness for their daily work, increased information provision, increased cooperation with other professionals, and increased frequency of questions to patients to awaken the patients’ own responsibility. All these findings are in concordance with those in the present Study IV. Müssener and Linderoth’s study (72), however, did not specifically address whether the participants experienced fewer problems after the educational intervention.

That the present intervention study may have had an effect is strengthened by the RNs’ descriptions in the evaluative interviews in Study IV. The main finding was the theme describing that the intervention had contributed to role clarity for the participating RNs. Role theory and research suggest that role clarity is important and has many positive effects on one’s working life, such as job performance, organizational commitment, job satisfaction, and self-efficacy (75).

Several descriptions by the RNs in Study IV indicate findings of experiencing higher job satisfaction and security in their role after participating in the intervention. For example, some RNs described that they increasingly experienced that they could help the patient, and also stated that this contributed to higher job satisfaction. Others described feeling more secure in their role, which could be a sign of higher self-efficacy.

By participating, the RNs described gaining knowledge of the sick leave process. This knowledge was gained not only through lectures but also through the interactive parts of the intervention: the reflection assignment and the discussions between participants and educators. In the reflection assignment, the RNs had the opportunity to describe and reflect on the practice with peers and course leaders. These experiences were referred to as positive by the RNs.

After participating in the intervention, the RNs experienced a number of changes in the handling of sick leave questions. They described this as ‘knowing what to say and do’ and ‘knowing where to turn for support’. They also experienced a change in communication with the callers, now offering
them more information due to ‘knowing what to say and do’. This was emphasized by almost all RNs as the most prominent experienced change. Other descriptions were being able to help the patient themselves as well as being more attentive, coaching, and encouraging towards patients. All these descriptions together can be seen as taking on more of the traditional tasks related to telephone nursing (i.e. collecting information; assessing care need; making decisions; giving advice, support and education; referring to the right level of care; giving health care information; and coordinating care) and thus taking on a larger role in this work.

Sandberg argues that altering/developing the understanding of work is the best way to develop competence (100, 104). According to Dall’Alba and Sandberg (100), this can be achieved by alternating between experiencing aspects of practice and the practice as a whole. In this way, the worker develops a professional identity that includes an understanding of both what to do and what it is to be a professional. In the present study, only a few RNs explicitly described having changed their understanding. One example is the previously mentioned RN who described an increased understanding of the patient’s vulnerability. Another is that RNs described that the knowledge of actors’ different roles and responsibilities gave them an understanding of why there are sometimes problems connected to sick leave and sickness certificates. It seemed that they could more easily address these requests after the intervention, as they now had an understanding of why they were needed.

Dall’Alba and Sandberg (100, 104) describe that the most competent workers perform tasks and thrive in their development according to their understanding of the work. This understanding drives what actions workers do at work. Some of the present study’s findings – RNs’ descriptions of offering increased support, coaching, and information in telephone calls – are descriptions of experienced changed actions. Thus, as the actions might have changed, it can be assumed that the understanding of the work also changed, compared to the previous actions and due to the intervention. The intervention did not include the patient perspective of encountering an RN with higher competence; this could be an aim in future research.

Concluding reflection

As described in the Prologue to this thesis, the motive for starting this work was the empathic and intuitive feeling as an RN that the patients I talked to were not doing well. This, combined with a frustration of my own insufficient competence in handling sick leave questions, was the departure point for this thesis.

Rather early in the process, triggered by the attitude of others, I realized that no one had noticed that the work of RNs in telephone nursing was a part
of the process for persons on sick leave. There was no role to develop, as RNs did not have a place. Nevertheless, we were evidently part of the process.

It has been very difficult to explore and map out a role that does not exist, and also to endure in the belief that RNs have something valuable to contribute. The language of the research area has been a great challenge that has contributed to this. It has taken until the end of writing this thesis for me to discover what has been missing all along; I have discovered that the concepts used in research on professionals’ work with sick leave have separated me from the meaning of what I as an RN do in health care; I care for persons on sick leave. Health care professionals do not simply work – our work is strongly related to the persons we care for, interpersonally and ethically.

The use of concepts to signal attitudes is indisputable: The work with sick leave questions should be called care of patients on sick leave.

Future studies

Future research might explore what could be experienced as creating more value, independence, and power for persons on sick leave.

Other studies could address the consequences of expanding the RN’s role in the sick leave process. This could be done by engaging RNs in rehabilitation team meetings, and examining how other professionals engaged in the sick leave process experience the RN’s role and competence as well as how patients are affected by RNs’ enhanced competence.

Methodological considerations

Criteria for quality are addressed here from two different perspectives depending on the study design: The trustworthiness of Studies I, II and IV is discussed from the qualitative criteria for conducting and assessing qualitative research by Lincoln and Guba: credibility, dependability, confirmability, and transferability (147). Credibility, the confidence that the interpretation of the data is truthful, involves performing the study in a way that enhances believability of the findings and also demonstrates this in the text for readers. Dependability is related to how consistent the data are: if the study were to be repeated, would it generate the same results? Confirmability establishes whether the data are representative of the participants’ descriptions or the researchers’ biases. Transferability is the extent to which the findings can be applied or transferred to other groups or settings (147).

The rigour of Study III is discussed based on the concepts of validity and reliability; quality criteria in quantitative research (109). Validity concerns whether there is evidence to support the alleged conclusions and whether the
methods used measure what they set out to measure. Reliability involves the consistency and accuracy of the results of a study (109).

**Trustworthiness (Studies I, II and IV)**

**Study I: A descriptive interview study with a phenomenological approach**

*Credibility:* Study I was designed to attain varying descriptions of being on sick leave in order to describe the essence of being on long-term sick leave. The interviewed persons had differing ages, genders, causes of sick leave and educations, which was thus a strength in attaining the aim. However, we did not succeed in including many participants with a foreign background, which is a limitation. An analysis of the invited persons who declined participation revealed that nine of 16, based on their names, seemed to be of foreign origin. Why they declined is not known, but several of them had difficulty communicating in Swedish when they were contacted with a request for participation. Offering an interpreter might have changed their decision.

The design for the study was based on the fundamental nursing ontology outlook that humans are dependent on and interconnected with the world they live in, the lifeworld (1, 111). An event like being on sick leave concerns the lifeworld of the person, and should preferably be studied from a lifeworld perspective.

As phenomenology offers the possibility to do this, it was chosen. However, in retrospect, the claim to have used this method should be more expressed as having used a phenomenology approach. By trying to attain the phenomenological attitude and trying to bracket preconceived ideas throughout the study, credibility was striven for. The researchers had different strategies for staying open to the meaning of the experience of being on long-term sick leave. One strategy included writing down ideas about their own perceived meaning of being on sick leave and to reflect together on how their own preconceived meanings could influence the analysis. It also included what Dahlberg describes as bridling (111, 130). This meant trying to stay open and not being too quick to find the meaning of being on sick leave.

The difference between phenomenological and manifest content analysis, which was used in Studies II and IV, relates to the phenomenological approach taken throughout the design and implementation in Study I, which was not the case in Studies II and IV. In Study I the philosophy of human consciousness described by Husserl (127) and developed by Giorgi (108, 113-115) served as a foundation for planning and performing the study. *Openness* to the subject’s descriptions is something common to both phenomenology and content analysis. However, in phenomenology the openness takes a much more explicit focus through reduction. In reduction, the influ-
ience of preconceived ideas with the researcher is bracketed (128, 129). How the researcher takes on the method and interprets how to use it, however, is subjective and it is up to the reader to assess the study’s trustworthiness.

**Confirmability:** Quotes have been displayed for the reader to confirm the findings.

**Dependability:** The main analysis was done by the first author. To enhance dependability, all the researchers read all the transcribed interviews and also discussed the formation of the different themes on several occasions. Many of the findings concerned negative and sometimes offensive experiences that had made a strong impression on the interviewer, the first author. The first author also had a pre-understanding from her own experience as a telephone nurse that persons on sick leave seemed to be stressed and worried. This made the first author question whether the interpretation of the findings was exaggerated in terms of being too generally negative. However, the first author probed the interviews several times to determine whether they are in concordance with the found themes and essence, and concluded that they do agree. This subject was also reflected on with the research group.

**Transferability:** The findings should be possible to transfer to patients being sickness certified in primary health care in Sweden. They can be used to enhance professionals’ understanding of experiences of the phenomenon of being on sick leave. The experience of illness is inseparable from that of sick leave; they intertwine, as in life. We have tried to describe the sample and setting, data collection, and data analysis as thoroughly as possible to enhance transferability and rigour in general.

**Study II: A descriptive focus group discussion study**

**Credibility:** Study II was designed to attain experiences of RNs handling sick leave questions in telephone nursing. When exploring a new phenomenon that has been only sparsely described previously, it is preferable to strive for maximum variation in sampling (109). However, the sampling technique (convenience sampling (109)) was not (as the concept informs us) done for variation; it was rather done out of convenience and feasibility reasons. This could be a limitation of the study. Another limitation is that the description of the sample is not very elaborate, which would otherwise have informed the reader about it.

There were three focus groups, one of which (b) had only three participants. According to Krueger (117), small groups are preferable as this allows more time and opportunity for every participant to share. Other methodological literature suggests at least four participants (109). The first author experienced that the smallest group generated the richest descriptions.

Each group consisted of participants working together on a daily basis. This could be a strength as well as a limitation. If the participants, due to knowing each other, felt comfortable, respected and free to give their opin-
ion, it was a strength. The opposite might have occurred if the participants did not feel comfortable to share. The beginning of the focus group discussions is critical for creating a permissive atmosphere and establishing comfort with the topic (117). The moderator of the group started the groups by encouraging the RNs to speak freely about their experiences, explaining the aim for and ground rules of the discussion, and going through the steps of consent provision. This hopefully contributed to an open and permissive discussion climate.

The focus group discussions generated rich and varying descriptions. To strengthen the credibility of the interpretations of the data, the analysis was done in constant reflection between two of the authors. The analysis process altered between looking at parts and the whole back and forth, according to Graneheim and Lundman’s (131) descriptions of how to analyse and identify similarities and differences between parts and the whole in a text.

Confirmability: To increase confirmability of the findings, the procedure of the study, quotes and an analysis scheme are presented.

Dependability: To enhance dependability, the discussion guide was tested in a pilot focus group discussion before the three focus groups, but this did not result in any alterations to the guide.

The first author, who was also the moderator, was employed in the same county as the participants but not at the same centre. This could have affected the discussions in some way. It was likely positive to have a moderator who was familiar with the organization. The first author also had personal experience of the subject being discussed. This could be positive as the moderator, based on personal experience, knew which areas were usually problematic or facilitating and could be attentive to whether these subjects were discussed.

Transferability: The findings’ transferability extends to primary health care settings in other counties in Sweden with similar conditions. The findings could also be of use when discussing sick leave questions in telephone nursing with RNs in other settings than primary health care, such as Swedish Healthcare Direct and specialist surgery telephone nursing at hospitals.

Study IV: A descriptive telephone interview study

Credibility: Study IV was designed to evaluate the experience of taking part in an educational intervention. The sampling was done to attain maximum variation (109) considering different primary health care centres, experience, and the possession of a specialist education or not. There is a possibility that it was RNs who were the most positive to the education who chose to participate. When ten interviews had been completed, the interviewer and the first author discussed whether saturation of the data (109) was experienced and the interviewer believed it was. After this, two more interviews were conducted that generated descriptions that had already been used, which confirmed the belief that saturation had been reached.
To enhance the study’s credibility, the interviews were performed by a researcher who not had been part of the educational intervention. The use of telephone interviews could be a strength as it enabled easy access to the participants, who did not need to take the time to travel to another place to be interviewed (148). On the other hand, it limits the interaction to verbal only.

**Confirmability:** Quotes and interview questions are made available for the reader to assess confirmability.

Dependability: The first author was part of the educational intervention, designing it as well as providing the educational intervention. As described earlier, this potential bias has been handled through having other researchers take part in the analysis and discussing it within the research group. The research group contained three researchers who had not had been part of the educational intervention and one who had.

**Transferability:** The findings should be possible to transfer to other counties in Sweden that perform educational interventions with RNs to increase their competence in handling sick leave questions in primary health care.

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**Rigour (Study III)**

**Study III: An explorative effect study of a randomized controlled educational intervention study**

*Validity:* Study III was designed to explore the effect of an educational intervention in social insurance medicine. A strength is that all primary health care centres in one county and all RNs working there were offered participation. While everyone did not respond to the request, in randomized controlled trials representativity versus a study population source, such as RNs in a primary health care unit, has no meaning. Much more important is representativity versus exposure, in this case the intervention (the educational intervention in social insurance medicine). Only half of those randomized to the intervention group attended the intervention. Despite this, however, there was a substantial effect of the intervention, even though it was inconclusive.

A limitation is that only one county participated and that, due to the small sample, the intervention failed to show a conclusive effect. The results should be treated cautiously, and further research with larger samples from several counties is necessary for generalizability.

Ideally, 300 participants should be included in a randomized controlled study to get equal values in all risk-affecting variables. Multiple tests were done. This could result in Type I errors, finding false positive conclusions of effects due to chance (109). However, most tests were used to single out exposure variables to be included in the analysis model, and only one test was done to obtain the result.

*Reliability:* A limitation is that the questionnaire not has been validated.
Conclusions

- The essential meaning of being on long-term sick leave – losing one’s independence – was connected to several dimensions of life, to being absent from work, to the social insurance rules, and to the experience in encounters with professionals. The described experiences were mostly negative, although some positive experiences were described.
- RNs’ work with sick leave questions in telephone nursing included actions that are common to all work in telephone nursing, namely assessment, dispositioning, and supportive and collaborative actions.
- RNs had a role in the care of patients on sick leave at the studied primary health care centres, but seemed to have different understandings of their role (different role identities). Some described being appointment bookers, while others described the role as more coherent to the ordinary telephone nursing role. Their role identity seemed to affect how they handled the telephone calls. The RNs described lacking the competence to handle sick leave questions contradictory demands in their roles as carers, co-workers, and distributors of organizational resources.
- The short educational intervention in social insurance medicine seemed to have had an effect, but due to the rather small study population, the effect was inconclusive.
- The short educational intervention was perceived to contribute to RNs gaining role clarity, by increasing their knowledge and skills in handling sick leave. All parts of the educational intervention – the lectures, discussions and reflection assignment – were described as useful in their present work.
- The RNs who had participated in the intervention described taking on more of the traditional tasks related to telephone nursing, for example giving more information and being more attentive, coaching and encouraging towards patients.
- Educational interventions in social insurance medicine seem to be a way to enhance and develop RNs’ care of patients on sick leave and their view of their role in the sick leave process.
Clinical implications

The finding that long-term sick leave can be experienced as very negative needs to be considered in health care. Not having information about what is going on in the process seems stressful for persons on sick leave, as do the many described negative psychological consequences and negative encounters. Hopefully, these findings illuminate the need for professionals involved in this work to increasingly consider each person’s support needs when on sick leave, and also consider organizing the health care in a way that addresses these problems.

The finding that the studied RNs had a role in the sick leave process at the studied centres displays a need to consider involving RNs in the process of sick leave in health care. The differences found in the understanding of the role call for RNs to be given opportunities to discuss and reflect on their role and the goals of the work. These findings also display a need for competence development for RNs in the sick leave process to be able to handle sick leave questions in a high-quality way. To reduce the stressful experience of contradictory demands, reflection within interprofessional teams may be helpful.

The findings of the educational intervention study indicate, albeit with inconclusive results, that a modest input of education in social insurance medicine could decrease perceived problems with handling sick leave questions. The process evaluation confirms increased knowledge and skills by using active methods like reflection and discussion.

If the role of RNs is clarified and developed, they could possibly contribute to a more high-quality and person-centred sick leave process for persons on sick leave by:

- Inquiring about patients’ experiences connected to their whole life, their possibility to participate in the process, and their needs
- Inquiring about patients’ psychological well-being
- Identifying and advocating for patients’ values and needs
- Identifying patients at risk for long-term sick leave
- Informing the patient about what is going on in the sick leave process
Att bli sjuk och inte kunna arbeta är något som drabbar nästan alla människor, i högre och lägre grad, under en livstid. Det är en oundviklig del av livet att ibland behöva hjälp av andra för att återhämta sig från sjukdom.

I Sverige erbjuds den som har reducerad arbetsförmåga på grund av sjukdom stöd från staten i en process som innefattar kontakt med olika aktörer som tillsammans ska hjälpa personen till återgång i arbete. Sjukskrivningsprocessen är komplex och kräver samarbete mellan inblandade aktörer och den drabbade personen för att bli effektiv.


Trots att vård av sjukskrivna patienter är mycket komplex så delar den och all annan vård samma utmaning: att kunna tillhandahålla det stöd som personen behöver för att återhämta sig och läka.

Denna avhandling utforskar den problematiska frågan om sjukskrivning i Primärvården från två perspektiv: personer som är sjukskrivna och sjuksköterskor.

Bakgrund
Forskning om personers upplevelser av att vara sjukskrivna, av konsekvenser av sjukskrivning och av möten med aktörer som är inblandade i sjukskrivningsprocessen är knapphändig. I de studier som finns beskrivs att möten med olika aktörer upplevs både som positiva och negativa. Ett antal studier beskriver att sjukskrivning påverkar livet negativt gällande sociala relationer och psykiskt välmående. Detta orsakar lidande för sjukskrivna personer och hindrar också återgång till arbete. För att förstå konsekvenser av sjukskrivning finns behov av studier som beskriver upplevelsen av att vara långtidssjukskriven ur ett livsvärldsperspektiv.

Sjuksköterskor har inte uppmärksammat för att vara en del av patienters sjukskrivningsprocess. De har inte heller involverats i kompetens- eller kvalitetshöjande åtgärder gällande området. Professionellas arbete med sjukskrivning i primärvård har huvudsakligen tidigare studerats utifrån läkares sjukskrivningspraxis. Sjuksköterskors roll i sjukskrivningsprocessen i telefon-
rådgivning är dock något annat än läkares kliniska praxis som innefattar att
agnostisera, behandla och sjukskriva patienter. Sjuksköterskor vårdar i
mötet via telefonen. Detta vårdmöte har som syfte att ge patienten ökade
möjligheter att förbättra, bibehålla eller återfå sin hälsa, hantera hälsopro-
blem, sjukdom eller funktionsnedsättning och uppnå bästa möjliga välbefin-
nande och livskvalitet fram till döden. Hur denna vård bedrivs är okänd. Det
är också okänt om hanteringen av sjukskrivningsfrågor skiljer sig från andra
frågor som hanteras i sjukvårdsrådgivning liksom hur sjuksköterskorna upp-
lever detta arbete och vad som ingår i det.

Idén med denna avhandling är att sjuksköterskor skulle kunna ta en större
roll i sjukskrivningsprocessen på vårdcentral om de erbjuds kompetensut-
veckling. Om sjuksköterskors roll i vårdandet av sjukskrivna patienter skulle
klargöras och stärkas så skulle detta kunna gynna inte bara sjuksköterskorna
utan också sjukskrivna patienter.

Syfte
Det övergripande syftet med avhandlingen var att utforska upplevelser av att
vara sjukskriven, att utforska sjuksköterskors roll i vården av sjukskrivna
patienter och att utforska effekten och upplevelsen av en utbildningsinter-
vention i försäkringsmedicin med sjuksköterskor.

Metod
Delstudie I var en intervjustudie med en fenomenologisk ansats och deskript-
tiv design. Sexton långtidssjukskrivna (> 3 månader) personer deltog i indivi-
duella intervjuer. Giorgis fenomenologiska metod användes vid analys av
data.

Delstudie II var en fokusgruppsstudie med deskriptiv design. Tre fokus-
grupper hölls med fjorton sjuksköterskor. Samtalen analyserades med mani-
fest kvalitativ innehållsanalys beskriven av Graneheim och Lundman.

Delstudie III var en explorativ effektstudie av en klusterrandomiserad in-
terventionsstudie. Ett hundra sjuksköterskor studerades avseende effekten av
interventionen på upplevelsen av problem med hantering av sjukskrivnings-
frågor. Data analyserades med tre modeller av nominal logistisk regression.

Delstudie IV var en intervjustudie med deskriptiv design. Tolv av de
sjuksköterskor som deltagit i utbildningsinterventionen intervjuades via tele-
fon. Data analyserades med manifest kvalitativ innehållsanalys beskriven av
Graneheim och Lundman.

Resultat
Sjukskrivna personers upplevelser: Den essentiella meningen med att vara
långtidssjukskriven var att förlora sin självständighet. Självständigheten
förlorades när deltagarna, på grund av sjukdom, var tvungna att sluta arbeta
och förlita sig på stöd från staten. Den osäkra läkningen, frånvaron från arbe-
tet och villkoren för att få stöd orsakade processer som för de flesta av delta-garna innebar försämrat förtroende för både dem själva och myndigheter.

*Sjuksköterskors arbete med sjukskrivningsfrågor* innefattade att bedöma, hänvisa, stödja och samarbeta. De uttryckte brist på kompetens och upplevde stress kopplat till motstridiga krav i deras roller som vårdare, kollegor och fördelare av organisationens resurser. Sjuksköterskorna hade också olika förståelse av rollen i arbetet med sjukskrivningsfrågor. En del sjuksköterskor reducerade sin roll till att vara tidsbokare medan andra såg att rollen innefattade alla de delar som den normalt sett gjorde vid hantering av andra typer av ärenden i telefonrådgivningen.

**Effekt och upplevelse av utbildningsintervention:** Utbildningsinterventionen verkade ha effekt men på grund av en liten studiepopulation så var effekten inte signifikant. Processutvärderingen visade att utbildningsinterventionen hade bidragit till upplevd klarhet i rollen i arbetet med sjukskrivningar. Sjuksköterskorna upplevde ökad kunskap och färdighet och att de tog sig an mer av de uppgifter som normalt ingår i telefonrådgivning, till exempel att ge mer information, att vara mer uppmärksam, coachande och uppmuntrande mot patienterna.

**Konklusion**


**Kliniska implikationer**

Resultatet att långtidssjukskrivning kan upplevas som mycket negativt behöver beaktas och hanteras i Hälso- och sjukvården. Sjukvårdspersonal som är involverad i sjukvårdsprocessen kan förhoppningsvis, i ljuset av dessa resultat, i ökad omfattning, beakta varje personas behov av stöd i sjukvården. Organiseringen av sjukvården behöver också förändras för att möta behovet av stöd.

Resultatet att sjuksköterskor har en roll i sjukvårdsprocessen vid de studerade vårdcentralerna visar på ett behov av att beakta om sjuksköterskor, i högre grad, ska involveras i sjukvårdsprocessen. Skillnaderna som beskrevs i hur rollen kan förstås uppmanar till att ge sjuksköterskor möjligheter att diskutera och reflektera över deras roll och mål med arbetet. Resultatet visar också på ett behov av kompetenshöjande åtgärder för att möjliggöra en god kvalité på vården av sjukskrivna. För att minska stressen av att
uppleva motstridiga krav kan möjligtvis reflektion i interprofessionella team vara av värde.

Resultatet från utbildningsinterventionen indikerar att trots en kort utbildningsintervention så verkar problem med hanteringen kunna minska, även om denna studie inte kunde visa på något signifikant resultat. Större studier behövs för att kunna fastställa effekten. Resultatet från intervjuerna i processutvärderingen bekräftar dock en upplevelse av ökad kunskap och färdighet genom aktiva inlärningsmetoder som reflektion och diskussion.

Om sjuksköterskans roll i sjukskrivningsprocessen klargörs och utvecklas så kan sjuksköterskor bidra till högre kvalité och personcentrering i sjukskrivningsprocessen genom att:

- Fråga efter patientens upplevelser kopplat till hela livet, om deras delaktighet i processen och om vilka behov de har.
- Fråga om patienternas psykiska mående.
- Identifiera och föra patientens talang gällande värderingar och behov.
- Informera patienten om vad som är på gång i dennes sjukskrivningsprocess.
- Identifiera personer som är i risk för långtidssjukskrivning.
Acknowledgements

My deepest thanks to everyone who participated in some way to make this thesis what it is. I would especially like to thank:

All the participating persons on sick leave for daring and wanting to share their stories, and also all the RNs for taking the time to participate.

Thorne Wallman, Associate Professor, PhD, MD, my main supervisor and co-author, for all the support, cheering and positive power you brought to this process. Meetings with you are always filled with good advice, anecdotes and a focus on the practical use of the knowledge we create.

Inger K. Holmström, Professor, PhD, RN, my second supervisor and co-author, for believing in me and wanting to take part in this adventure. You are a fantastic researcher with a razor-sharp focus on what is most important. Thank you for being a researcher role model for me, and for helping me stick to the RN perspective.

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My friends: Thank you for putting up with me, encouraging and comforting me in both good and bad times!

My parents: Anna-Greta and Hans. Thank you for always believing in me and always grounding me in what is really important. Pappa, thanks for always being there for me and my family, and for fixing things and taking care of the dogs. Mamma, I miss you so much. I wish you could have been here with me to celebrate. Your passion, love, and laugh live in me forever.

My family: Josef, Albert and Jonatan. I love you so much, you give my life meaning. Josef, you are my rock and my best friend. Thank you for all the things you have done to ease things for me these last years. Albert, thank you for always introducing new, interesting facts about everything and nothing, for watching movies with me, for listening to my thoughts and for designing and illustrating the cover of this thesis. Jonatan, thank you for always understanding me, for always having something comforting to say or do, and for all the joy you bring into my life!


46. Svensson T, Müssener U, Alexanderson K. Sickness absence, social relations, and self-esteem: a qualitative study of the importance of relationships with fami-


73. Omvårdnad i primärvården [Care in primary health care]. Lund: Studentlitteratur; 2013.


76. Nilsson A. Personal communication with the director of Primary Healthcare Division, Sörmland County Council. 2016.


## Bakgrund

<table>
<thead>
<tr>
<th>Dagens datum</th>
<th>År 20____ Månad _______ Dag ______</th>
</tr>
</thead>
</table>

1. Vilket år är du född? __________________

2. Kön
   - □ Kvinna
   - □ Man

3. Har du specialistsjuksköterskeexamen?
   - □ Ja
   - □ Nej
   Om ja, vilken?
   - □ distriktssköterska
   - □ hälso- och sjukvård för barn och ungdomar
   - □ annan________________________(ange vilken)
   - □ med magisterexamen

4. Hur länge har du totalt arbetat med telefonrådgivning på vårdcentral?
   - □ mindre än 1 år
   - □ 1-5 år
   - □ 6-9 år
   - □ 10 år eller längre

5. På vilken typ av vårdcentral arbetar du?
   - □ landstingsdriven
   - □ privat

6. Vilken tjänstgöringsgrad har du?
   - □ Heltid
   - □ Deltid

7. Hur stor del av din arbetstid arbetar du med telefonrådgivning?
   - □ 50 -100 %
   - □ mindre än 50 %
8. Har du varit sjukskriven mer än sju dagar sammanhängande senaste fem åren?  
☐ Ja  ☐ Nej

9. Har Ni på Din mottagning en gemensam policy för handläggning av sjukskrivningsärenden?  
☐ Ja  ☐ Nej  ☐ Vet ej

10. Innehåller sjukskrivningsärenden ett arbetsmiljöproblem för dig?  
(Arbetsmiljö= allt som påverkar en arbetstagare på arbetet)  
☐ Ja, i stor utsträckning  ☐ Ja, i viss mån  ☐ Nej

11. Har du stöd från din närmaste ledning på mottagningen kring handläggning av sjukskrivningsärenden?  
☐ Ja, i stor utsträckning  ☐ Ja, i viss mån  ☐ Nej

12. Upplever Du att Du har en roll i vården av sjukskrivna patienter?  
☐ Ja  ☐ Nej

Om ja, beskriv din roll

_____________________________________________________
_____________________________________________________
_____________________________________________________

(önskar Du mer plats att skriva på finns det på enkätens sista sida)

Kunskap

13. Har du någon utbildning i försäkringsmedicin?  
☐ Nej  ☐ Ja

Om ja, vilken?
☐ Internutbildning på min arbetsplats
☐ Annan________________________

_________________________(ange vilken)
14. Hur ofta i Ditt arbete i telefonrådgivning möter Du patienter som söker för frågor relaterade till sjukskrivning?

<table>
<thead>
<tr>
<th>Alternativ</th>
<th>Fler än 20 ggr/vecka</th>
<th>6-20 ggr/vecka</th>
<th>1-5 ggr/vecka</th>
<th>Någon ggn/månad</th>
<th>Några ggr/år</th>
<th>Aldrig/i stort sett aldrig</th>
</tr>
</thead>
</table>

15. Inom den svenska offentliga sjukförsäkringen finns flera olika typer av ersättningar. Vilka känner du till och vet du när de ska tillämpas?

*Tag ställning till varje alternativ, flera kryss på varje rad är möjligt*

<table>
<thead>
<tr>
<th>Ersättning</th>
<th>Känner till</th>
<th>Vet när den tillämpas</th>
<th>Vet ej</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sjuklön</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sjukpenning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sjukersättning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aktivitetsersättning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Förebyggande sjukpenning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smittbärarpennning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sjuk närstående</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arbetsskada</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Vilken/vilka av följande faktorer avgör om en person får ersättning från sjukförsäkringen?

- Arbetsförmåga
- Sjukdom
- Annat_________

____________(ange vad)

17. Vad är den vanligaste orsaken till långvarig sjukskrivning?

(ange ett alternativ)

- Symtom från rörelseorganen
- Cancer
- Infektioner
- Psykiska besvär
- Vet ej

18. Påverkas hälsan av långtidssjukskrivning?

- Nej
- Ja
- Vet ej

Om Ja, hur påverkas hälsan?

- positivt
- negativt

90
19. Är kvinnor mer sjukskrivna än män?
- Ja
- Nej
- Vet ej

20. Är lågutbildade är oftare sjukskrivna än högutbildade?
- Ja
- Nej
- Utbildningsnivån har inget samband med sjukskrivning

21. Den årliga kostnaden för den Svenska sjukförsäkringen är
- En halv miljard kronor
- En miljard kronor
- Tio miljarder kronor
- Ett hundra miljarder kronor

22. Känner Du till Socialstyrelsens försäkringsmedicinska beslutsstöd med rekommendationer för sjukkrivning utifrån sjukdomar och tillstånd?
- Ja
- Nej

23. Upplever Du att landstinget satsar på att förbättra sjukvårdens handläggning av patienters sjukskrivning?
- Ja
- Nej

24. Vilken/vilka av följande åtgärder vidtar du i samband med handläggning av sjukkrivningsärenden i telefonrådgivning?
Tag ställning till varje alternativ och ange ett svar på varje rad

<table>
<thead>
<tr>
<th>Alltid</th>
<th>Ofta</th>
<th>Ibland</th>
<th>Aldrig</th>
</tr>
</thead>
<tbody>
<tr>
<td>…bokar läkartid</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>…bokar telefontid hos läkare</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>…ger information om sjukförsäkringsregler</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>…hänvisar till annan vårdgivare</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>…hjälper till att reda ut frågor/problem gällande sjukskrivning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>…annan____________________________</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

____________________________ (ange vad)
25. Vilken/vilka av följande faktorer avgör vilken åtgärd du vidtar? 
*Tag ställning till varje alternativ och ange ett svar på varje rad*

<table>
<thead>
<tr>
<th></th>
<th>Alltid</th>
<th>Ofta</th>
<th>Ibland</th>
<th>Aldrig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beskrivna sjukdomssymtom</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Socialförsäkringens regler</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Anteckningar i patientens journal</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tillgång till läkartider</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>annat______________________________</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

(ange vad)

26. I vilken utsträckning har följande hjälpt dig att utveckla din kompetens gällande hantering av sjukskrivningsärenden? 
*Tag ställning till varje alternativ och ange ett svar på varje rad*

<table>
<thead>
<tr>
<th></th>
<th>Mycket</th>
<th>Ganska mycket</th>
<th>Lite</th>
<th>Inte alls</th>
<th>Ej aktuellt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grundutbildning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Specialistutbildning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Utbildning i försäkringsmedicin</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Eget sökande efter kunskap (litteratur, internet etc)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kontakter med sjuksköterskekollegor och/eller annan personal inom vården</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kontakter med patienter</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kontakter med personer inom Försäkringskassan</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Information i massmedia</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Undervisa och handleda andra i dessa frågor</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Konferenser, seminarier</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Försäkringsmedicinskt beslutsstöd</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
annat____________________
_____________________
(ange vad)

27. Hur ofta i ditt arbete med telefonrådgivning...

<table>
<thead>
<tr>
<th></th>
<th>Fler än 10 ggr/vecka</th>
<th>6-10 ggr/vecka</th>
<th>1-5 ggr/vecka</th>
<th>Någon gång/månad</th>
<th>Några ggr/år</th>
<th>Aldrig/i stort sett aldrig</th>
</tr>
</thead>
<tbody>
<tr>
<td>...upplever du att sjukskrivningsärenden är problematiska?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...upplever du att det är svårt att göra en bedömning om vilken åtgärd du ska göra i ett telefonsamtal gällande sjukskrivningsärende?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...möter du en patient som vill vara sjukskriven av annan anledning än arbetsoförmåga orsakad av sjukdom/skada?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...upplever du att patienten har förväntningar på sjukskrivning som inte stämmer överens med sjukförsäkringens regler?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...upplever du konflikter med patienter kring sjukskrivning?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...upplever du att du får medla mellan patient och läkare i ett sjukskrivningsärende?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...känner du dig hotad av en patient kring sjukskrivning?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...säger en patient att hon/han tänker byta läkare om läkaren inte sjukskriver?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...samråder du med sjuksköterskekollega om hur du ska hantera ett sjukskrivningsärende?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...samråder du med rehabiliteringskoordinator om hur du ska hantera ett sjukskrivningsärende?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>...samråder du med patientens läkare/annan läkare om hur du ska hantera ett sjukskrivningsärende?</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>
28. Hur problematiskt tycker du det i allmänhet är att…
Tag ställning till varje alternativ och ange ett svar på varje rad

<table>
<thead>
<tr>
<th>Alternativ</th>
<th>Mycket</th>
<th>Ganska</th>
<th>Lite</th>
<th>Inte alls</th>
</tr>
</thead>
<tbody>
<tr>
<td>…veta vilket information du ska ge en patient gällande sjukskrivningsärende?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>…veta var du ska hänvisa patienten?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>…hantera patienter som är missnöjda i samband med sjukskrivningsärenden</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>annat</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

__________________________________________________________
(ange vad)

29. Hur stort behov har du av att fördjupa din kompetens inom följande områden?
Tag ställning till varje alternativ och ange ett svar på varje rad

<table>
<thead>
<tr>
<th>Alternativ</th>
<th>Mycket</th>
<th>Stort</th>
<th>Ganska stort</th>
<th>Litet</th>
<th>Inget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regelsystemet kring sjukförsäkringen</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hur läkaren arbetar med sjukskrivningsärenden</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hur Rehabiliteringsteamet och Rehabiliteringskoordinator arbetar med sjukskrivningsärenden</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Försäkringskassans roll i samband med sjukskrivning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Arbetsgivarens roll i samband med sjukskrivning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hantera konflikter med patienter kring behov av sjukskrivning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
30. Hur värderar du följande alternativ för hög kvalitet i ditt arbete med sjukskrivningsärenden i telefonrådgivning? 
_Tag ställning till varje alternativ och ange ett svar på varje rad_

<table>
<thead>
<tr>
<th>Alternativ</th>
<th>Stort värde</th>
<th>Måttligt värde</th>
<th>Inget värde</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kontakter med sjuksköterskekollegor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kontakter med behandlande läkare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kontakter med Rehabkoordinator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dokumentation i patientens journal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handledning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Försäkringsmedicinskt beslutsstöd</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gemensam policy för din arbetsplats gällande handläggning av sjukskrivningsärenden</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Särskild rutin för sjuksköterskors handläggning av sjukskrivningsärenden i telefonrådgivningen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skriftlig information ex från Försäkringskassan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kurser och konferenser</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Få uppföljande statistik om hur din vårdcentral sjukskrivit senaste året</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bättre information om sjukförsäkringssystemet till allmänheten</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mer tid för varje telefonsamtal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31. Tycker du att man ska kunna vara sjukskriven i följande situationer? När man:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Instämmer helt</th>
<th>Instämmer inte alls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Är mobbad på arbetsplatsen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har barn med problem som behöver ens stöd</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Instämmer helt</td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Har svårt att komma över en separat-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ion/skilsmässa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>År missnöjd med organisation på arbetet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har planerat att vara ledig men inte får sem-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har en pressad livssituation och inte klarar av att gå till arbetet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Känns sig stressad av sitt arbete</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har konstant värk som man inte kunnat få någon hjälp med</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Är förkyld med bara litet feber</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har kraftig övervikt och inte orkar sköta sitt arbete</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har drogproblem med minnesluckor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har huvudvärk efter att ha druckit för mycket alkohol kvällen innan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vill protestera mot arbetsgivaren</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har gjort sitt i arbetslivet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Är arbetslös och arbetslös-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>löshetsdagarna håller på att ta slut</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Är trött på grund av dålig sömn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lever under hot och måste hålla sig gömd</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
32. Instämmer du i följande påståenden?

<table>
<thead>
<tr>
<th>Instämmer för sjukskrivning är alldeles för stränga</th>
<th>Instämmer helt</th>
<th>Instämmer delvis</th>
<th>Instämmer inte alls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Konstrollen av de sjukskrivna är alldeles för sträng</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kvinnors arbetsbörda i hemmet gör att de är sjukskrivna längre än män som har ungefär samma sjukdom/skada</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Det är lätt att förstå vilka regler som gäller för ersättning vid sjukdom</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Måna av de sjukskrivna är egentligen inte sjuka</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Arbetsgivarna gör för lite för att förebygga att det blir sjukskrivningar</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Man kan lita på att försäkringskassan gör rätt bedömning av individens rätt till sjukpenning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Det är för lätt att få sjukpenning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Läkarna följer patienternas önskemål om att bli sjukskrivna</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Man kan lita på att sjukförsäkringen kommer att ge ett tillräckligt skydd i framtiden</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Många sjukskrivna arbetar mot betalning samtidigt som de är helt sjukskrivna</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Instämmer helt</td>
<td>Instämmer delvis</td>
<td>Instämmer inte alls</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>Arbetsgivarna gör allt som är möjligt för att de sjukskrivna snabbt ska återgå i arbete</td>
<td>Ersättningsnivåerna i sjukförsäkringen är tillräckliga</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Man kan lita på att sjukvården ställer rätt diagnos och behandling utan dröjsmål</td>
<td>Försäkringskassorna skulle kunna göra mer för att få de sjukskrivna att återgå i arbete</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jag kan tänka mig att arbeta mot betalning trots att jag är helt sjukskriven</td>
<td>Arbetsgivaren skulle kunna göra mer på arbetsplatsen för att minska sjukskrivningar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jag känner deltidssjukskrivna som jag tycker borde kunna vara helt friskskrivna</td>
<td>Jag är beredt att byta arbete, yrke eller flytta till annan ort om jag blir sjuk/skadad och inte klarar av mina vanliga arbetsuppgifter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Det är bättre att vara sjukskriven i stället för att riskera att bli arbetslöś under en längre tid om man inte kan fortsätta att arbeta på sin arbetsplats på grund av sjukdom/skada</td>
<td>Sjukförsäkringssystemet passiviserar den sjukskrivne</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Plats för eventuella kommentarer:

Tack för Din medverkan!
Appendix 2 Supplementary Table Study III

**Supplementary Table. Crude odds ratio in Study III.**

<table>
<thead>
<tr>
<th>Model</th>
<th>Exposure</th>
<th>Estimate (SE)</th>
<th>Wald’s $\chi^2$ square</th>
<th>Degree of explanation</th>
<th>Odds ratio</th>
<th>95% confidence interval</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude odds ratios</td>
<td>Intervention vs. control group</td>
<td>-0.4992 (0.53)</td>
<td>0.89</td>
<td>80 %</td>
<td>0.61</td>
<td>0.22-1.71</td>
<td>0.35</td>
</tr>
<tr>
<td>Age at baseline</td>
<td></td>
<td>-0.0164 (0.03)</td>
<td>0.39</td>
<td>80%</td>
<td>0.98</td>
<td>0.93-1.04</td>
<td>0.53</td>
</tr>
<tr>
<td>Has worked with telephone nursing ≥6 years</td>
<td></td>
<td>0.4366 (0.31)</td>
<td>2.04</td>
<td>81%</td>
<td>1.55</td>
<td>0.85-2.82</td>
<td>0.15</td>
</tr>
<tr>
<td>Telephone nursing ≥50% of working hours</td>
<td></td>
<td>0.0430 (0.52)</td>
<td>0.01</td>
<td>76%</td>
<td>1.04</td>
<td>0.38-2.88</td>
<td>0.93</td>
</tr>
<tr>
<td>Work place policy for handling sick leave</td>
<td></td>
<td>-0.6976 (0.80)</td>
<td>0.75</td>
<td>78%</td>
<td>0.50</td>
<td>0.10-2.41</td>
<td>0.39</td>
</tr>
<tr>
<td>Gets no support from managers</td>
<td></td>
<td>-0.1564 (0.37)</td>
<td>0.18</td>
<td>78%</td>
<td>0.86</td>
<td>0.41-1.77</td>
<td>0.67</td>
</tr>
<tr>
<td>Propensity score</td>
<td></td>
<td>1.6022 (1.15)</td>
<td>1.94</td>
<td>84%</td>
<td>4.96</td>
<td>0.52-47.24</td>
<td>0.16</td>
</tr>
</tbody>
</table>
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