Respectful encounters and return to work – empirical study of long-term sick-listed patients' experiences of Swedish healthcare

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Respectful encounters and return to work – empirical study of long-term sick-listed patients' experiences of Swedish healthcare

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Abstract

Aims: To study long-term sick-listed patients' self-estimated ability to return to work after experiences of healthcare encounters that made them feel either respected or wronged.

Methods: A questionnaire-based survey was used to study a sample of long-term sick-listed patients including n=5 802 respondents. The survey included questions about positive and negative encounters as well as about reactions to these encounters, such as 'feeling respected' and 'feeling wronged'. The questionnaire also included questions about the effects of these encounters on the patients' ability to return to work.

Results: Among patients who had experienced positive encounters, those who also felt respected presented significantly augmented self-estimated ability to return to work [from 34% (CI: 28-40) to 62% (CI: 60-64)]. Among patients with experiences of negative encounters, those who in addition felt wronged claimed to be significantly more impeded from returning to work [from 31% (CI: 27-35) to 50% (CI: 47-53)].

Conclusions: The study indicates that positive encounters in healthcare combined with feeling respected significantly facilitate sickness absentees' self-estimated ability to return to work, while negative encounters combined with feeling wronged significantly impair it.

Article summary

- Do different encounters influence sick-listed patients' self-estimated ability to return to work?
- What happens if positive encounters are also perceived as respectful?
- What happens if negative encounters are also perceived as wrongful?

- Patients' self-estimated ability to return to work are significantly facilitated if encounters are perceived as respectful and significantly impeded if encounters are perceived as wrongful.

- We examined solely the perceived ability to return to work, not the actual ability to return to work.

Introduction

During the last decade, there have been several interventions to reduce the previously high sick-leave rates in Sweden [1]. The rate of long-term sick-leave cases was particularly high [2]. Different interventions have aimed to increase the quality of the management of sickness certification, but more knowledge is needed on how return to work can be promoted among long-term sickness absentees [1-4].

Some studies indicate that patients' experiences of healthcare encounters might influence their chances of returning to work [5]. Being listened to, having one's questions answered, and being believed are among the most common items associated with positive encounters among long-term sick-listed patients and have also been reported to be important in relation to feeling respected in healthcare; correspondingly, experiences of nonchalance, disrespect, and distrust are commonly associated with negative encounters and are important in relation to feeling wronged [6].

The aim of the present study was to examine how, in the experience of patients on long-term sick leave, positive and negative encounters in healthcare affect their self-estimated possibility of returning to work, and how much difference, if any, it makes whether or not these experiences are accompanied by feeling respected and feeling wronged, respectively.

Material and methods

The present study derives from a population-based questionnaire survey among randomly selected long-term sickness absentees (n=10 042) who in 2003 had an ongoing sick-leave spell that had lasted for six to eight months. Of these 5 802 answered the questionnaire. The survey was distributed during 2004 and different aspects of the survey have already been reported [7-9]. In the present study we have examined the respondents' experiences using a questionnaire containing questions about positive or negative encounters, what kinds of encounters they had been exposed to, and how they reacted in terms of feeling respected or wronged. The patients were also asked to estimate how these encounters had affected their ability to return to work, in terms of hindering, not influencing, or facilitating return to work, respectively. In addition, the respondents were asked if they were sick-listed for (a) psychiatric disorders, (b) musculoskeletal pain, (c) other somatic

diseases, or (d) more than one of the previous categories. When presenting the results, we focus on respondents in a–c.

The results are presented as proportions (with 95% confidence intervals (CI)) of those who estimated that return to work was facilitated, compared to those who stated that return to work was not influenced or impeded, when experiencing positive encounters/feeling respected, and of those who felt impeded, compared to those who stated that return to work was not influenced or facilitated, when experiencing negative encounters/feeling wronged. Focusing on the association between respectful/wrongful encounters and return to work, we have performed logistic regression analysis adjusting for different background variables such as sex, age, educational level, and different diagnoses. Adjustment made, however, no substantial difference to the results. Accordingly, we here present the crude proportions with a 95% CI.

The frequency and associations between positive encounters and feeling respected, and negative encounters and feeling wronged, are presented as Attributable Risks (AR) [10] with a 95% CI, using the R-package pARtial [11]. Since a majority of all encounters concerned physicians (70%), we have replaced the wording “healthcare providers including physiotherapists and midwifes” with “physicians” in the text.

The study was approved by the regional research ethics committee in Linköping (Dnr 03-261).

Results

The response rate was 58% (n=5 802) of the original sample. Of the participants who had experienced positive encounters (n=3 406), 97.7% (CI: 97.2-98.2) stated that they also felt respected. Among those who had experienced negative encounters (n=1 403), 70.8% (CI: 68.4-73.2) declared they also felt wronged (Figure 1).

When comparing patients who had experienced negative encounters and felt wronged with those who had experienced negative encounters but not felt wronged, we found a significantly higher proportion of patients in the former category who reported that they were impeded from returning to work [50% (CI: 47-53) versus 31% (CI: 27-35)] (Table 1). When adding feeling wronged to negative encounters, the self-rated hindering effect on return to work was highest among patients on sickness absence for ‘psychiatric

disorders' [38% (29-37) as against 59% (CI: 54-64)] and lowest among those sick-listed for 'other somatic conditions' [28% (19-37) as against 39% (CI: 32-47)] (Table 2).

The patients who stated that they had experienced positive encounters and felt respected claimed to a significantly higher degree that return to work was facilitated by the encounter, compared to those who experienced positive encounters but did not feel respected [62% (CI: 60-64) versus 34% (CI: 28-40)] (Table 1). When adding feeling respected to positive encounters, the self-rated facilitating effect on return to work was highest among those sick-listed for 'other somatic conditions' [23% (5-41) as against 54% (51-58)] and lowest among patients sick-listed for 'psychiatric disorders' [53% (29-77) as against 76% (74-79)] (Table 3).

There was no significant difference between women and men, but we noticed a tendency for women who felt respected to reply more often that this had increased their ability to return to work; [63% (CI: 61-64) for women as against 59% (CI: 56-61) for men]. Men, on the other hand, tended to be more inclined to find themselves impeded from returning to work if feeling wronged [55% (CI: 48-61) as against 49% (CI: 45-52) for women].

Discussion

We found that patients on long-term sick leave experienced positive healthcare encounters as facilitating return to work, while negative encounters impeded it. The facilitating effect of positive encounters was significantly augmented when combined with the patient's feeling respected, while return to work was significantly reduced if negative encounters were combined with feeling wronged. Feeling respected had a greater effect in relation to positive encounters regarding return to work than feeling wronged had in relation to negative encounters (Table 1).

Encounters may affect return to work

Insofar as the respondents' experiences fully or partly reflect their actual ability to return to work, they identify a number of aspects of physician–patient interaction that have to be handled properly in order to facilitate patients' chances of returning to work. There is much discussion on how to promote return to work among long-term sickness absentee

patients, focusing on different types of rehabilitation measures [3,5]. The present study suggests that physicians and other healthcare staff may also have an impact on patients' ability to return to work through the way in which they encounter patients. This tallies with the results of an interview study indicating that such encounters had as high an impact on return to work as the rehabilitation measures [12].

Patients' understanding of being respected and being wronged

It should be noted that the survey does not give any details about what the respondents meant by feeling respected and feeling wronged. In medicine, respecting patients usually relates to respecting their right to autonomous decision-making. Physicians are supposed not only to respect patient autonomy but also to enhance it, for example, by support and encouragement. Showing respect for patient autonomy might enhance patients' self-esteem and enable them to accomplish more [5]. It may thus facilitate their self-estimated as well as their actual ability to return to work. In practice, showing respect for patient autonomy might concern basic things like treating them as competent and showing a genuine interest in what they say.

This is not to say that a list of basic components of reasonable behaviour towards patients exhausts the meaning of treating them with respect. We found that something was added when the patients felt not only that they had experiences of positive healthcare encounters, but also that they felt respected, as was shown in their estimations of their ability to return to work. What this addition more specifically consists in cannot be learnt from our questionnaire survey, but deserves to be further examined.

Corresponding remarks can be made regarding negative encounters and feeling wronged. Instead of empowering patients' self-esteem, experiences of being wronged might make patients impaired and decrease their ability to return to work. Thus, disrespecting patient autonomy is not only regrettable as such, but might have negative consequences for patients' wellbeing [13].

Feeling wronged is, however, not necessarily the same actually being wronged, and it might be debated whether patients sometimes provoke the doctor to act in a less appropriate way [14-15]. Provoked or not, there may be situations where patients

perceive the doctor as intimidating, condescending, or patronising, while the physician does not realise until afterwards that the encounter could be perceived that way [15].

We find it interesting that patients who were sickness absent due to psychiatric disorders seemed to be more affected by feeling wronged in their encounters than those with somatic disorders. Perhaps psychiatric patients are more sensitive to having their autonomy questioned. But when feeling respected was added to the experience of positive encounters, it had little influence on patients sick-listed for psychiatric disorders. In this case, patients with 'other somatic conditions' were the most sensitive group. We have no explanation for this inverse result.

Limitations

Since our data concern a special patient group, the results may not be generalisable to the general patient population. Long-term sick listed patients may, for instance, have faced greater disappointments in their healthcare contacts than many other patient groups. They may also have had more experience of not being believed. However, regarding the effect of positive encounters, our results are supported by other studies. One study points to a reduction in sick-leave duration for patients suffering from tonsillitis [16], while another study identifies improvements in HbA1c and LDL-cholesterol for patients suffering from diabetes [17].

Another limitation is that the study concerns patients' self-estimations of the influence of positive and negative healthcare encounters on their ability to return to work. Such estimates may be difficult to make, and patients may over- or underestimate the influence of these encounters. Further research is needed to establish the influence of positive and negative healthcare encounters on the ability to return to work in real life.

A third limitation is the drop out, which, as is so often the case, is somewhat higher among men and younger patients. Compared to other studies of sick people, the response rate was high and the large number of subjects provides a solid base for conclusions.

Conclusion

Our study indicates that feeling respected in healthcare significantly facilitates long-term sick-listed patients' self-estimated ability to return to work, while feeling wronged significantly impairs it.

Contributorship statement:

Niels Lynøe made the first statistical analysis and made the draft. Maja Wessel and Daniel Olsson conducted all further statistical analyses and contributed to the second and final draft. Kristina Alexanderson and Gert Helgesson contributed both substantially and intellectually with critical analysis and contribution to the second and final draft.

Financial statement:

We have not received any funding for this specific study.

Competing interest statement:

We have received no support from any organisation for the submitted work; we have had no financial relationships with any organisations that might have an interest in the submitted work in the previous three years; there are no other relationships or activities that could appear to have influenced the submitted work

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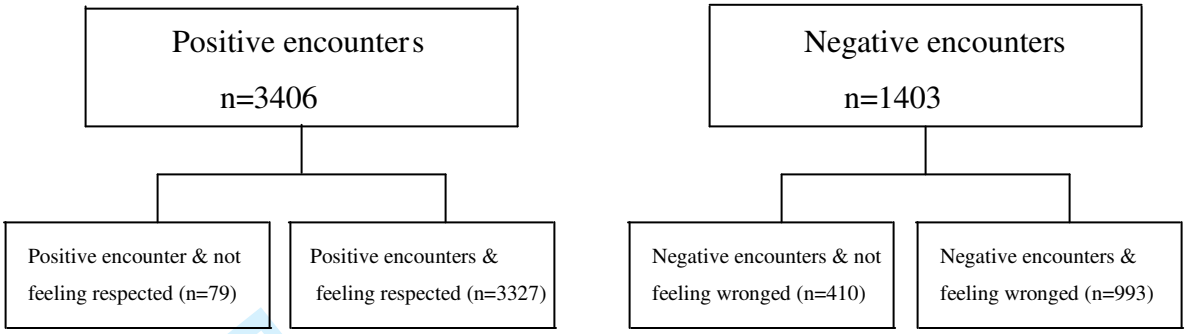

Figure 1. The left-hand side of the figure displays the distribution of answers regarding experiences of positive encounters with healthcare in relation to self-estimated influence on return to work. The sample is divided into those who experienced positive encounters but did not feel respected and those who experienced positive encounters and felt respected. The right-hand side of the figure shows the distribution of answers regarding negative encounters in relation to self-estimated influence on return to work. The sample is divided into those who did not feel wronged and those who felt wronged.

Table 1. Self-estimated effect, among long-term sick-listed patients, of positive and negative healthcare encounters on return to work in relation to feeling/not feeling respected and feeling/not feeling wronged. The results are presented as proportions of those who were facilitated, not influenced, or impeded, with a 95% confidence interval.

	Return to work was:		
	Facilitated	Not influenced	Impeded
Positive encounters			
Not feeling respected (n=79)	34% (28-40)	63%	3%
Feeling Respected (n=3327)	62% (60-64)	37%	1%
Negative encounters			
Not feeling wronged (n=410)	8%	61%	31% (27-35)
Feeling wronged (n=993)	4%	46%	50% (47-53)

Table 2. The table shows patients' self-estimated ability to return to work when feeling wronged, in relation to reason for sickness absence: (1) psychiatric disorders, (2) musculoskeletal pain, or (3) other somatic disorders. The table shows the proportion of statements to the effect that return to work was facilitated, not influenced, or impeded as the patients felt wronged in their healthcare encounters.

	Return to work was:		
Type of medical disorder	Facilitated	Not influenced	Impeded
Psychiatric disorders			
Not feeling wronged (n=104)	5%	57%	38% (29-37)
Feeling wronged (n=316)	4%	37%	59% (54-64)
Musculoskeletal disorders			
Not feeling wronged (n=142)	7%	66%	27% (20-34)
Feeling wronged (n=302)	7%	49%	44% (38-49)
Other somatic disorders			
Not feeling wronged (n=86)	5%	67%	28% (19-37)
Feeling wronged (n=161)	4%	57%	39% (32-47)

Table 3. The table displays the patients' self-estimated ability to return to work when feeling respected, in relation to reason for sickness absence: (1) psychiatric disorders, (2) musculoskeletal pain, or (3) other somatic disorders. The table shows the proportion of statements to the effect that return to work was facilitated, not influenced, or impeded as the patients felt respected in their healthcare encounters.

	Return to work was:		
Type of medical disorder	Facilitated	Not influenced	Impeded
Psychiatric disorders			
Not feeling respected (n=17)	53% (29-77)	47%	0%
Feeling respected (n=931)	76% (74-79)	23%	1%
Musculoskeletal disorders			
Not feeling respected (n=28)	28% (11-45)	68%	4%
Feeling respected (n=1018)	53% (50-56)	45%	2%
Other somatic disorders			
Not feeling respected (n=22)	23% (5-41)	73%	4%
Feeling respected (n=798)	54% (51-58)	45%	1%

RESEARCH CHECKLIST

As far as we understand, this requirement is not applicable to this questionnaire-based study.

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Abstract

Aims: To study long-term sick-listed patients' self-estimated ability to return to work after experiences of healthcare encounters that made them feel either respected or wronged.

Methods: A cross-sectional and questionnaire-based survey was used to study a sample of long-term sick-listed patients including n=5 802 respondents. The survey included questions about positive and negative encounters as well as about reactions to these encounters, such as 'feeling respected' and 'feeling wronged'. The questionnaire also included questions about the effects of these encounters on the patients' ability to return to work.

Results: Among patients who had experienced positive encounters, those who also felt respected (n=3327) presented significantly augmented self-estimated ability to return to work, compared to those who did not feel respected (n=79) [from 34% (CI: 28-40) to 62% (CI: 60-64)]. Among patients with experiences of negative encounters, those who in addition felt wronged (n=993) claimed to be significantly more impeded from returning to work, compared to those who did not feel wronged (n=410) [from 31% (CI: 27-35) to 50% (CI: 47-53)].

Conclusions: The study indicates that positive encounters in healthcare combined with feeling respected significantly facilitate sickness absentees' self-estimated ability to return to work, while negative encounters combined with feeling wronged significantly impair it.

Introduction

During the last decade, there have been several interventions to reduce the previously high sick-leave rates in Sweden [1]. The rate of long-term sick-leave cases has been particularly high [2]. Different interventions have aimed to increase the quality of the management of sickness certification, but more knowledge is needed on how return to work can be promoted among long-term sickness absentees [1-4].

Some studies indicate that patients' experiences of healthcare encounters might influence their chances of returning to work [5]. Being listened to, having one's questions answered, and being believed are among the most common items associated with positive encounters among long-term sick-listed patients and have also been reported to be important in relation to feeling respected in healthcare; correspondingly, experiences of nonchalance, disrespect, and distrust are commonly associated with negative encounters and are important in relation to feeling wronged [6].

The aim of the present study was to examine how, in the experience of patients on long-term sick leave, positive and negative encounters in healthcare affect their self-estimated possibility of returning to work, and how much difference, if any, it makes whether or not these experiences are accompanied by feeling respected and feeling wronged, respectively.

Material and methods

The present study derives from a population-based and cross-sectional questionnaire survey among randomly selected long-term sickness absentees (n=10 042) who in 2003 had an ongoing sick-leave spell that had lasted for six to eight months. Of these 5 802 answered the questionnaire. The survey was distributed during 2004, and different aspects of the survey have already been reported [7-9]. In the present study we have examined the respondents' experiences using a questionnaire containing questions about positive and negative encounters, what kinds of encounters they had been exposed to, and how they reacted in terms of feeling respected or wronged. The response-options were "yes" and "no" to the questions regarding whether or not they had experiences of positive and negative encounters in healthcare. When asked about how the participants felt when experiencing positive and negative encounters, there were several response options, such

as: I felt respected/wronged, I was happy/disappointed, I felt satisfied/became angry, etc. The participants were asked to respond whether or not they agreed/disagreed completely or agreed/disagreed to a large extent. When presenting the results, those who agreed completely or to a large extent were collapsed into one group (agree) and so were those who disagreed completely or to a large extent (do not agree).

The patients were also asked to estimate how these encounters had affected their ability to return to work, in terms of being impeded, not being influenced, or being facilitated. Response options were not being influenced,being impeded, facilitated very much, or impeded, facilitated to a certain extent. When presenting results, the latter response-options were collapsed into those who were impeded or facilitated. In addition, the respondents were asked if they were sick-listed for (a) psychiatric disorders, (b) musculoskeletal pain, (c) other somatic diseases, or (d) more than one of the previous categories. When presenting the results, we focus on respondents in a–c.

The results are presented as proportions (with 95% confidence intervals (CI)) of those who estimated that return to work was facilitated, compared to those who stated that return to work was not influenced or impeded, when experiencing positive encounters/feeling respected, and of those who felt impeded, compared to those who stated that return to work was not influenced or facilitated, when experiencing negative encounters/feeling wronged. Focusing on the association between respectful/wrongful encounters and return to work, we have performed logistic regression analysis adjusting for different background variables such as sex, age, educational level, and different diagnoses. Adjustment made, however, no substantial difference to the results. Accordingly, we here present the crude proportions with a 95% CI.

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The response rate was 58% (n=5 802) of the original sample. Of the participants who had experienced positive encounters (n=3 406), 97.7% (CI: 97.2-98.2) stated that they also felt respected. Among those who had experienced negative encounters (n=1 403), 70.8% (CI: 68.4-73.2) declared they also felt wronged (Figure 1).

When comparing patients who had experienced negative encounters and felt wronged with those who had experienced negative encounters but not felt wronged, we found a significantly higher proportion of patients in the former category who reported that they were impeded from returning to work [50% (CI: 47-53) versus 31% (CI: 27-35)] (Table 1). When adding feeling wronged to negative encounters, the self-rated hindering effect on return to work was highest among patients on sickness absence for 'psychiatric disorders' [38% (29-37) as against 59% (CI: 54-64)] and lowest among those sick-listed for 'other somatic conditions' [28% (19-37) as against 39% (CI: 32-47)] (Table 2).

The patients who stated that they had experienced positive encounters and felt respected claimed to a significantly higher degree that return to work was facilitated by the encounter, compared to those who experienced positive encounters but did not feel respected [62% (CI: 60-64) versus 34% (CI: 28-40)] (Table 1). When adding feeling respected to positive encounters, the self-rated facilitating effect on return to work was highest among those sick-listed for 'other somatic conditions' [23% (5-41) as against 54% (51-58)] and lowest among patients sick-listed for 'psychiatric disorders' [53% (29-77) as against 76% (74-79)] (Table 3).

There was no significant difference between women and men, but we noticed a tendency for women who felt respected to reply more often that this had increased their ability to return to work; [63% (CI: 61-64) for women as against 59% (CI: 56-61) for men]. Men, on the other hand, tended to be more inclined to find themselves impeded from returning to work if feeling wronged [55% (CI: 48-61) as against 49% (CI: 45-52) for women].

Discussion

We found that patients on long-term sick leave experienced positive healthcare encounters as facilitating return to work, while negative encounters impeded it. The

facilitating effect of positive encounters was significantly augmented when combined with the patient's feeling respected, while return to work was significantly reduced if negative encounters were combined with feeling wronged. Feeling respected had a greater effect in relation to positive encounters regarding return to work than feeling wronged had in relation to negative encounters (Table 1).

Encounters may affect return to work

Insofar as the respondents' experiences fully or partly reflect their actual ability to return to work, they identify a number of aspects of physician–patient interaction that have to be handled properly in order to facilitate patients' chances of returning to work. There is much discussion on how to promote return to work among long-term sickness absentee patients, focusing on different types of rehabilitation measures [3,5]. The present study suggests that physicians and other healthcare staff may also have an impact on patients' ability to return to work through the way in which they encounter patients. This tally with the results of an interview study indicating that such encounters had as high an impact on return to work as the rehabilitation measures [12].

Patients' understanding of being respected and being wronged

It should be noted that the survey does not give any details about what the respondents meant by feeling respected and feeling wronged. In medicine, respecting patients usually relates to respecting their right to autonomous decision-making. Physicians are supposed not only to respect patient autonomy but also to enhance it, for example, by support and encouragement. Showing respect for patient autonomy might enhance patients' self-esteem and enable them to accomplish more [5]. It may thus facilitate their self-estimated as well as their actual ability to return to work. In practice, showing respect for patient autonomy might concern basic things like treating them as competent and showing a genuine interest in what they say.

This is not to say that a list of basic components of reasonable behaviour towards patients exhausts the meaning of treating them with respect. We found that something was added when the patients felt not only that they had experiences of positive healthcare encounters, but also that they felt respected, as was shown in their estimations of their

ability to return to work. What this addition more specifically consists in cannot be learnt from our questionnaire survey, but deserves to be further examined. For instance, people might understand 'being respected' as being respected as a person more broadly and not solely as having one's autonomy respected.

Corresponding remarks can be made regarding negative encounters and feeling wronged. Instead of empowering patients' self-esteem, experiences of being wronged might make patients impaired and decrease their ability to return to work. Thus, disrespecting patients is not only regrettable as such, but might have negative consequences for their wellbeing [13].

Feeling wronged is, however, not necessarily the same as actually being wronged, and it might be debated whether patients sometimes provoke the doctor to act in a less appropriate way [14-15]. Provoked or not, there may be situations where patients perceive the doctor as intimidating, condescending, or patronising, while the physician does not realise until afterwards that the encounter could be perceived that way [15].

We find it interesting that patients who were sickness absent due to psychiatric disorders seemed to be more affected by feeling wronged in their encounters than those with somatic disorders. Perhaps psychiatric patients are more sensitive to having their autonomy questioned. But when feeling respected was added to the experience of positive encounters, it had little influence on patients sick-listed for psychiatric disorders. In this case, patients with 'other somatic conditions' were the most sensitive group. We have no explanation for this inverse result.

Limitations

Since our data concern a special patient group, the results may not be generalisable to the general patient population. Long-term sick listed patients may, for instance, have faced greater disappointments in their healthcare contacts than many other patient groups. They may also have had more experience of not being believed. However, regarding the effect of positive encounters, our results are supported by other studies. One study points to a reduction in sick-leave duration for patients suffering from tonsillitis [16], while another study identifies improvements in HbA1c and LDL-cholesterol for patients suffering from diabetes [17].

Another limitation is that the study concerns patients' self-estimations of the influence of positive and negative healthcare encounters on their ability to return to work. Such estimates may be difficult to make, and patients may over- or underestimate the influence of these encounters. Further research is needed to establish the influence of positive and negative healthcare encounters on the ability to return to work in real life.

A third limitation is the drop out, which, as is so often the case, is somewhat higher among men and younger patients. Compared to other studies of sick people, the response rate was high and the large number of subjects provides a solid base for conclusions.

Conclusion

Our study indicates that feeling respected in healthcare significantly facilitates long-term sick-listed patients' self-estimated ability to return to work, while feeling wronged significantly impairs it.

Competing interest statement:

No support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years [or describe if any], no other relationships or activities that could appear to have influenced the submitted work

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Table 1. The table shows the self-estimated effect, among long-term sick-listed patients, of positive and negative healthcare encounters on return to work in relation to feeling/not feeling respected and feeling/not feeling wronged. The results are presented as proportions of those who were facilitated, not influenced, or impeded, with a 95% confidence interval.

	Return to work was:		
	Facilitated	Not influenced	Impeded
Positive encounters			
Not feeling respected (n=79)	34% (28-40)	63%	3%
Feeling Respected (n=3327)	62% (60-64)	37%	1%
Negative encounters			
Not feeling wronged (n=410)	8%	61%	31% (27-35)
Feeling wronged (n=993)	4%	46%	50% (47-53)

Table 2. The table shows patients who have experienced negative healthcare encounters and their self-estimated ability to return to work when feeling/not feeling wronged, in relation to reason for sickness absence: (1) psychiatric disorders, (2) musculoskeletal pain, or (3) other somatic disorders. The table shows the proportion of statements to the effect that return to work was facilitated, not influenced, or impeded as the patients felt wronged/not wronged in their healthcare encounters.

	Return to work was:		
Type of medical disorder	Facilitated	Not influenced	Impeded
Psychiatric disorders			
Not feeling wronged (n=104)	5%	57%	38% (29-37)
Feeling wronged (n=316)	4%	37%	59% (54-64)
Musculoskeletal disorders			
Not feeling wronged (n=142)	7%	66%	27% (20-34)
Feeling wronged (n=302)	7%	49%	44% (38-49)
Other somatic disorders			
Not feeling wronged (n=86)	5%	67%	28% (19-37)
Feeling wronged (n=161)	4%	57%	39% (32-47)

Table 3. The table displays patients who have experienced positive healthcare encounters and their self-estimated ability to return to work when feeling/not feeling respected, in relation to reason for sickness absence: (1) psychiatric disorders, (2) musculoskeletal pain, or (3) other somatic disorders. The table shows the proportion of statements to the effect that return to work was facilitated, not influenced, or impeded as the patients felt respected/not respected in their healthcare encounters.

	Return to work was:		
Type of medical disorder	Facilitated	Not influenced	Impeded
Psychiatric disorders			
Not feeling respected (n=17)	53% (29-77)	47%	0%
Feeling respected (n=931)	76% (74-79)	23%	1%
Musculoskeletal disorders			
Not feeling respected (n=28)	28% (11-45)	68%	4%
Feeling respected (n=1018)	53% (50-56)	45%	2%
Other somatic disorders			
Not feeling respected (n=22)	23% (5-41)	73%	4%
Feeling respected (n=798)	54% (51-58)	45%	1%

Checklist of items of the present cross-sectional questionnaire-based study entitled Respectful encounters and return to work – empirical study of long-term sick-listed patients' experiences of Swedish healthcare - bmjopen-2011-000246.R1

STROBE 2007 (v4) checklist of items to be included in reports of observational studies in epidemiology*
Checklist for cohort, case-control, and cross-sectional studies (combined)

Section/Topic	Item #	Recommendation	Reported on page #
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract	1
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found	1
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	2
Objectives	3	State specific objectives, including any pre-specified hypotheses	2
Methods			
Study design	4	Present key elements of study design early in the paper	2-3
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	2-3
Participants	6	(*a*) *Cohort study*—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up *Case-control study*—Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls *Cross-sectional study*—Give the eligibility criteria, and the sources and methods of selection of participants	2
		(*b*) *Cohort study*—For matched studies, give matching criteria and number of exposed and unexposed *Case-control study*—For matched studies, give matching criteria and the number of controls per case	NA
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	2-3
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	*2-3*
Bias	9	Describe any efforts to address potential sources of bias	2-3
Study size	10	Explain how the study size was arrived at	2
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	2-3

Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding	3
		(*b*) Describe any methods used to examine subgroups and interactions	3
		(*c*) Explain how missing data were addressed	3
		(*d*) *Cohort study*—If applicable, explain how loss to follow-up was addressed *Case-control study*—If applicable, explain how matching of cases and controls was addressed *Cross-sectional study*—If applicable, describe analytical methods taking account of sampling strategy	3
		(*e*) Describe any sensitivity analyses	NA
Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	2-3
		(b) Give reasons for non-participation at each stage	2-3
		(c) Consider use of a flow diagram	10
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	2-3
		(b) Indicate number of participants with missing data for each variable of interest	2-3
		(c) *Cohort study*—Summarise follow-up time (eg, average and total amount)	NA
Outcome data	15*	*Cohort study*—Report numbers of outcome events or summary measures over time	NA
		Case-control study—Report numbers in each exposure category, or summary measures of exposure	NA
		Cross-sectional study—Report numbers of outcome events or summary measures	2-3
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	2-3 + 11-13
		(*b*) Report category boundaries when continuous variables were categorized	NA
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	-
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	2-3
Discussion			
Key results	18	Summarise key results with reference to study objectives	4-5
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	6-7
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	6-7
Generalisability	21	Discuss the generalisability (external validity) of the study results	6
Other information			

Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	NA

*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.
Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.

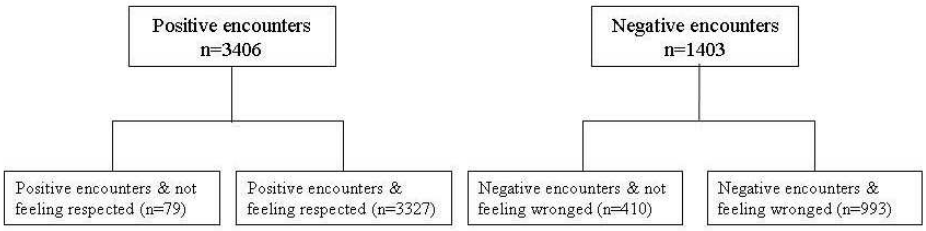

Figure 1. The left-hand side of the figure displays the distribution of answers regarding experiences of positive encounters with healthcare in relation to self-estimated influence on return to work. The sample is divided into those who experienced positive encounters but did not feel respected and those who experienced positive encounters and felt respected. The right-hand side of the figure shows the distribution of answers regarding negative encounters in relation to self-estimated influence on return to work. The sample is divided into those who did not feel wronged and those who felt wronged.

77x61mm (300 x 300 DPI)