

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 cross-sectional and questionnaire-based survey was used to study a sample of long-term sick-listed patients (n=5802 respondents). The survey included questions about positive and negative encounters as well as 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) demonstrated significantly improved self-estimated ability to return to work compared to those who did not feel respected (n=79) (62% (95% CI 60% to 64%) vs 34% (95% CI 28% to 40%)). 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) (50% (95% CI 47% to 53%) vs 31% (95% CI 27% to 35%)).

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, several interventions have aimed at reducing the high sick-leave rates in Sweden.¹ The rate of long-term sick-leave has been particularly high.² Different interventions have sought to improve 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

ARTICLE SUMMARY

Article focus

- To what extent can positive and perceived respectful healthcare encounters influence long-term sick-listed patients' ability to return to work?
- To what extent can negative and perceived unfair healthcare encounters influence long-term sick-listed patients' ability to return to work?

Key messages

- Long-term sick-listed patients' self-estimated ability to return to work is significantly facilitated if healthcare encounters are perceived as respectful.
- Long-term sick-listed patients' self-estimated ability to return to work is significantly impeded if healthcare encounters are perceived as unfair.
- The net effect of feeling respected was highest among patients with somatic disorders, while the net effect of feeling wronged was highest among patients with psychiatric disorders.

Strengths and limitation of this study

- The study sample was large and we obtained quite a high response rate.
- The outcome measure was the respondents' self-estimated ability to return to work, not their actual ability.
- The findings are based on the views of long-term sick-listed patients and so generalisation may not be possible.

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. Correspondingly, experiences of nonchalance, disrespect and distrust are commonly associated with negative encounters.

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 ability to return to work, and what difference, if any, it makes if these experiences are accompanied by feelings of being respected or wronged.

MATERIAL AND METHODS

The present study derives from a population-based and cross-sectional questionnaire survey conducted among randomly selected long-term sickness absentees (n=10 042) who in 2003 had an ongoing sick-leave spell that had lasted for 6–8 months. There were 5802 respondents to the survey which was conducted in 2004; the results of other aspects of the survey have been previously reported.^{6–8} In the present study we have examined the respondents' experiences using a questionnaire asking about positive and negative encounters, what kinds of encounters they had experienced and how they reacted in terms of feeling respected or wronged. The response options were 'yes' and 'no' to the questions whether or not they had experiences of positive and negative encounters in healthcare. To the questions asking 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 whether or not they completely agreed/disagreed or largely agreed/disagreed with the option. When the results were analysed, those who completely or largely agreed were collapsed into one group (agree) as were those who completely or largely disagreed (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, being facilitated very much or being facilitated to a certain extent. When results were analysed, the response options were collapsed into those who were impeded and those who were 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 categories a–c.

The results are presented as proportions (with 95% CIs) 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/unfair encounters and return to work, we performed logistic regression analysis adjusting for different background variables such as sex, age, educational level and different diagnoses. However, adjustment made no substantial difference to the results. Accordingly, we present the crude proportions with 95% CIs.

The frequency and associations between positive encounters and feeling respected, and negative encounters and feeling wronged, are presented as attributable risks (AR)⁹ with a 95% CI, using the R-package pARtial.¹⁰ Since a majority of all encounters concerned physicians (70%), we have replaced the wording 'healthcare providers including physiotherapists and midwives' in the questionnaire 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=5802) of the original sample. Of the participants who had experienced positive encounters (n=3406), 97.7% (95% CI 97.2% to 98.2%) stated that they also felt respected. Among those who had experienced negative encounters (n=1403), 70.8% (95% CI 68.4% to 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% (95% CI 47% to 53%) vs 31% (95% CI 27% to 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

Figure 1 The left-hand side of the figure shows the distribution of answers regarding experiences of positive healthcare encounters 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 and did feel wronged.

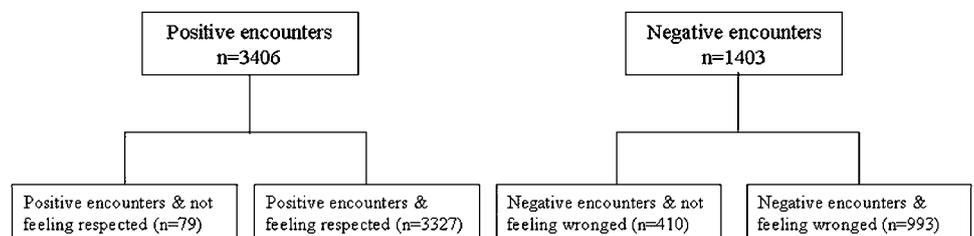


Table 1 Self-estimated effect among long-term sick-listed patients of positive and negative healthcare encounters on return to work in relation to feeling/not feeling respected and feeling/not feeling wronged

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

The results are presented as proportions (95% CIs).

'psychiatric disorders' (38% (95% CI 29% to 37%) vs 59% (95% CI 54% to 64%)) and lowest among those sick-listed for 'other somatic conditions' (28% (95% CI 19% to 37%) vs 39% (95% CI 32% to 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% (95% CI 60% to 64%) vs 34% (95% CI 28% to 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% (95% CI 5% to 41%) vs 54% (95% CI 51% to 58%)) and lowest among patients sick-listed for 'psychiatric disorders' (53% (95% CI 29% to 77%) vs 76% (95% CI 74% to 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% (95% CI 61% to 64%) for women vs 59% (95% CI 56% to 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% (95% CI 48% to 61%) vs 49% (95% CI 45% to 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 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, these findings identify a number of aspects of physician-patient interactions 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 absentees, which focuses 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 they interact with patients. This agrees with the results of an interview study indicating that such encounters had as great an impact on return to work as rehabilitation measures.¹¹

Table 2 Patients who experienced negative healthcare encounters and their self-estimated ability to return to work when feeling/not feeling wronged, in relation to the reason for sickness absence

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

The results are presented as proportions (95% CIs).

Table 3 Patients who experienced positive healthcare encounters and their self-estimated ability to return to work when feeling/not feeling respected, in relation to the reason for sickness absence

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

The results are presented as proportions (95% CIs).

Patients' understanding of being respected and being wronged

It should be noted that the survey does not provide any details as to 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 to respect patient autonomy and 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 involve basic good manners such as treating the patient as competent and showing a genuine interest in what they say.

However, a list of reasonable behaviours towards patients does not cover all aspects of treating them with respect. We found that something was added when the patients felt that they had experienced positive healthcare encounters and also felt respected, as was shown by their estimations of their ability to return to work. What this addition more specifically consists of cannot be determined from our questionnaire survey, but does deserve to be further examined. For instance, people might understand 'being respected' as being respected more broadly as a person and not solely as having one's autonomy respected.

Similar remarks can be made regarding negative encounters and feeling wronged. Instead of empowering patients' self-esteem, experiences of being wronged might impair patients and decrease their ability to return to work. Thus, disrespecting patients is regrettable in itself and might also have negative consequences for their wellbeing.¹²

Feeling wronged is, however, not necessarily the same as actually being wronged, and it may be that patients sometimes provoke the doctor to act in a less appropriate way.^{13 14} 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 have been perceived that way.¹⁴

We find it interesting that patients who were absent from work 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. However, 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 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 report points to a reduction in sick-leave duration for patients with tonsillitis,¹⁵ while another study identifies improvements in HbA1c and LDL-cholesterol in patients with diabetes.¹⁶

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 non-response rate, which, as is so often the case, is somewhat higher among men and younger patients. Compared to other patient studies, 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 encounters significantly facilitates long-term sick-listed patients' self-estimated ability to return to work, while feeling wronged significantly impairs it.

Correction notice The "To cite: ..." information and running footer in this article have been updated with the correct volume number (volume 1).

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Competing interests None.

Ethics approval The Research Ethics Committee in Linköping approved this study (Dnr 03-261).

Contributors NL had the original idea for the present study, took the leading part in its conception and design, conducted the first statistical analysis, contributed substantially to the interpretation of results, wrote the first draft of the manuscript and participated in critical revision of later versions. MW and DO conducted all further statistical analyses, contributed to the interpretation of results and critically revised the manuscript. KA conceived and designed the questionnaire and was responsible for data acquisition. She contributed substantially to the interpretation of results and critically revised the manuscript. GH contributed substantially to the conception and design of the study and to the interpretation of results. He had a leading role in the revision of the manuscript.

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