

Sickness absence and 'working through' illness: a comparison of two professional groups

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Abstract

Background Few studies have investigated occupational groups reporting low rates of sickness absence because of an assumption that these rates indicate low morbidity. This is inconsistent with the view that sickness absence, which may be caused by social and psychological rather than medical factors, does not equate with morbidity. This paper investigates rates of sickness absence and factors influencing decisions not to take sick leave among doctors and a comparative professional group.

Methods A postal survey was sent to 670 general practitioners (GPs), 669 hospital doctors and 400 company 'fee earners'. Qualitative interviews were conducted with 64 doctors reporting an illness lasting one month or more in the last three years.

Results Self-reported health status was similar for both groups but GPs reported higher levels of occupational stress. However, doctors were significantly less likely to report short periods of sick leave in the previous year. Over 80 per cent of all respondents had 'worked through' illness, citing cultural and organizational factors behind their decision not to take sick leave. Barriers to sick leave among doctors included the difficulty of arranging cover and attitudes to their own health.

Conclusions Considerable emphasis has been given to the role of social factors in contributing to rates of sickness absence. These may also contribute to the decision not to take sick leave, resulting in possible inappropriate non-use. Measures to encourage and enable doctors to take sick leave might improve the management of their own health.

Keywords: sickness absence, doctors' health, illness behaviours

Introduction

Absenteeism has long been considered problematic in the National Health Service (NHS), with health care workers reported to have one of the highest rates of sickness absence of all occupational sectors.¹ However, there are wide variations between different occupational groups involved in the delivery of health care. Hospital doctors take little sick leave compared with other hospital employees, including nurses, ancillary and manual staff.^{2–5} General practitioners (GPs) have been reported to take less sick leave than school teachers.⁶

However, although doctors' rates of sickness absence have been reported they have rarely been discussed because low

absence is assumed to indicate low morbidity and to present no economic or managerial problem. One manager recently implied that doctors provide an example to other NHS employees, attributing their good attendance to their sense of commitment.⁷ Yet in the context of increasing concern for doctors' health,^{8,9} such assumptions should be questioned. This paper examines responses to ill-health and the factors influencing sickness absence among doctors and a comparative group (company 'fee earners') also known to have low rates of sickness absence. We investigate the extent to which low rates simply reflect a low incidence of health problems; variations between 'low-risk' groups' sickness absence rates; and how these might be explained, including the importance of factors which discourage workers from taking sick leave. The data were collected as part of our study *Doctors' health and needs for services*.¹⁰

Methods

Survey

Postal questionnaires were sent to 669 hospital doctors employed by three Trusts, 670 GPs in two Family Health Services Authorities (FHSAs) in a mixture of urban and rural settings and 400 graduate employees of a multi-national accountancy company, working both in London and other offices throughout the United Kingdom. These were accountants and management consultants classified as 'fee earners' with responsibility for completing projects for external clients. This group was selected because, like doctors, they have high socio-economic status, they often undertake lengthy post-graduate training, and they work in an environment and sector which was assumed to be 'stressful', an assumption borne out by our findings reported below.

Lists for distribution of the questionnaire to doctors were supplied by medical staffing in hospital trusts and by FHSAs.

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Two follow-ups were carried out among the medical respondents. The company personnel department carried out random selection and questionnaire distribution among the fee earners but was unable to carry out any follow-up.

The short anonymous postal questionnaire asked about demographic details, perceptions of own health, stress at work, sickness absence, use of health services, and respondents' views on needs for health services.

Measuring sickness absence presents problems in the NHS (as in other sectors) with variations in the methods and quality of record keeping.^{2,11} After inquiries to hospital medical staffing departments, we decided to collect self-reported data, which have been shown to be reliable.¹²

The outcome variables of interest are no sick leave taken (0 days sick leave in the last year), longer spells of sick leave (last spell >7 days) and willingness to take sick leave.

Variations in the age and sex distributions of each professional group were investigated using one-way analysis of variance and the χ^2 test of significance. Logistic regression, adjusting for age and sex, was used to examine the effect of profession on outcome. The interactions between age and profession, and sex and profession were tested and found not to be significant. The odds ratios reported are age and sex adjusted. Nonlinearity of age was also tested. This was not significant and so age is included in the model as a continuous variable.

Qualitative study

Semi-structured interviews were conducted with 64 doctors. They were recruited through a 1-page questionnaire sent to GPs in two FHSAs and doctors in one hospital and notices in the medical press. Issues investigated were access to care, mechanisms of support available to them, sick leave, the impact of illness and the return to work, their perceptions of care received and their attitudes towards illness. Interviews were audiotape recorded and transcribed for thematic analysis.

Results

Survey sample

Questionnaires were returned by 1279 respondents, giving a 73.5 per cent response rate. These were 532 (79 per cent) GPs, 506 (76 per cent) hospital doctors and 241 (60 per cent) company fee earners. Table 1 shows the sex and age distribution of the three professional groups. Mean age differed significantly across professional groups ($p=0.0001$), with company fee earners being the youngest group and GPs the oldest group (Table 1).

Respondents' health and work-related stress

Respondents were asked to rank their own health on a four-point scale ('excellent', 'good', 'average' or 'poor'). A total of 467 (87.8 per cent) GPs, 461 (91.1 per cent) hospital doctors and 224 (92.9 per cent) company fee earners assessed their

Table 1 Sex, age distribution and mean age of respondents by professional group

	GPs		Hospital doctors		Company fee earners	
	No.	%	No.	%	No.	%
<i>Sex</i>						
Male	354	66.5	336	66.4	176	73.0
Female	178	33.5	170	33.6	65	27.0
<i>Age (years)</i>						
20-29	8	1.5	144	28.4	50	20.7
30-39	171	32.2	142	28.1	139	57.7
40-49	190	35.7	125	24.7	40	16.6
50-59	120	22.5	75	14.8	8	3.3
60-69	36	6.8	19	3.8	—	—
unknown	7	1.3	1	0.2	4	1.7
Mean age	44.5		38.5		34.7	
SD	9.3		10.9		6.6	

health as 'excellent' or 'good'. A hospital admission in the previous three years was reported by 80 (15 per cent) GPs, 68 (13.5 per cent) hospital doctors and 28 (11.8 per cent) company fee earners. After adjusting for age and sex these differences were not significant.

There were no significant differences in levels of overall job satisfaction reported by respondents. Asked to rank an overall level of occupational stress on a five-point scale from 'never stressful' to 'always stressful', 369 (69 per cent) GPs, 256 (51 per cent) hospital doctors and 139 (58 per cent) company fee earners reported that their job is 'often' or 'always stressful'.

Use of services and sickness absence

Registration with a GP was reported by 517 (98 per cent) GPs, 446 (88 per cent) hospital doctors and 232 (97 per cent) company fee earners, but use of health services varied between professions. Last consultation with a doctor was reported to be one year or more ago by 38 per cent of company fee earners, 60 per cent of hospital doctors and 65 per cent of GPs. Although most respondents' last medical consultation was with their own GP, for 67 (14 per cent) GPs and 106 (23 per cent) hospital doctors this was an informal consultation with a colleague. Twenty-three (4.3 per cent) GPs, 12 (2.4 per cent) hospital doctors and 7 (2.9 per cent) company fee earners reported having consulted a counsellor within the last three years.

Respondents were asked how many days sick leave they had taken in the last year (Table 2). The adjustment made by fitting the model is minimal. Profession was significantly associated with the number of days sick leave reported, with GPs [odds ratio 4.1, 95 per cent confidence interval (CI) 1.2-2.4] and hospital doctors (odds ratio 2.7, 95 per cent CI 1.9-3.7) more likely than company fee earners to report no sick leave in the last year.

Table 2 Percentage of professional groups reporting categories of days sick leave taken in the last year (figures in parentheses are adjusted to age 40 years)

Days sick leave	GPs		Hospital doctors		Company fee earners	
	males (n = 354)	females (n = 178)	males (n = 336)	females (n = 170)	males (n = 176)	females (n = 65)
0	65.0 (66.0)	65.2 (59.3)	58.0 (55.9)	42.9 (48.6)	31.8 (32.4)	21.5 (26.3)
1-3	22.0	18.5	27.1	36.5	43.2	49.2
4-7	3.7	5.6	8.0	11.2	17.6	20.0
>7	9.3	10.7	6.9	9.4	7.4	9.2

Respondents were then asked how many days they had been absent from work on their most recent period of sickness absence. There were 960 responses to this question: 73 per cent of GPs, 70 per cent of hospital doctors and 87 per cent of company fee earners. Table 3 shows that most absences reported were 1-3 days. However, GPs (odds ratios 4.2, 95 per cent CI 1.9-9.5) and hospital doctors (odds ratio 2.9, 95 per cent CI 1.3-6.6) were more likely than company fee earners to report spells of >7 days.

As there is a problem of recall in responding to this question, we then examined the responses of the sub-group of 578 respondents who reported taking some sick leave in the last year. The same pattern was repeated: 37 (20 per cent) GPs, 28 (12 per cent) hospital doctors, and 2 (1 per cent) company fee earners said that their last sickness absence was for a period of >7 days.

Attitudes towards taking sick leave

In response to the question, 'Have you ever continued to work where it might have been better to take sick leave?' 458 (86 per cent) GPs, 429 (85 per cent) hospital doctors and 212 (88 per cent) company fee earners replied 'yes'.

An open-ended question elicited reasons for not taking sick leave (Table 4). Doctors and company fee earners phrased their responses differently but most responses indicated that 'working through' illness occurs when the individual believes that work cannot wait or cannot be delegated. Respondents in both occupational groups referred to factors in the organization of

work and work ethic. Comments coded under the latter category include 'commitment to the job', 'taking sick leave is disapproved of' and 'workaholicism'. Most company fee earners simply attributed their working through illness to 'pressure of work'. About half the GPs in the sample cited their reluctance to 'burden' their partners with extra work. GPs also referred specifically to problems associated with engaging locums, including cost and availability at short notice.

Professional differences in willingness to take sick leave were explored further by a hypothetical question: 'If you woke in the morning with a streaming cold and a headache would you take the day off work?' (Table 5). GPs (odds ratio 16.2, 95 per cent CI 10.8-24.3) and hospital doctors (odds ratio 2.9, 95 per cent CI 1.9-4.4) were more likely than company fee earners to respond 'definitely not'.

Qualitative study: sick leave among recently ill doctors

Sixty-four doctors (36 men and 28 women) ranging from 27 to 65 years were interviewed. There were 40 GPs, 23 hospital doctors (11 consultants, 12 trainee grades) and one member of the armed forces. Although the sample was self-selected, there were variations in geographical location, disease category and medical specialization. Thirty-six doctors had experienced a physical illness or disorder; 24 had a psychiatric disorder; four had both physical and psychiatric problems.

Reluctance to acknowledge illness, which was equated with admitting to inability to cope, led to some delays in seeking help. Self-diagnosis and treatment were common, as were

Table 3 Percentage of professional groups reporting each last spell of sick leave

Sick leave (days)	GPs (n = 389)	Hospital doctors			Company fee earners (n = 213)
		Juniors (n = 165)	Consultants (n = 167)	All (n = 358)*	
1-3	60.4	72.3	76.6	72.3	85.0
4-7	13.6	12.3	12.0	12.3	11.7
>7	26.0	15.4	11.4	15.4	3.3

*Includes 26 hospital doctors who gave no information about their grade.

Table 4 Main reasons for 'working through' illness

Reasons given	Hospital doctors				Company fee earners (n = 212)
	GPs (n = 458)	Juniors (n = 220)	Consultants (n = 179)	All (n = 429)	
'Pressure of work'	0.7	0.5	6.2	2.9	63.4
'Unfair to colleagues'	50.3	35.2	14.5	26.4	—
'Patients booked'/prior commitments'	19.5	7.0	31.9	19.7	5.2
'No cover'/no-one else to do my work'	12.4	34.7	33.0	33.0	23.5
No locums available	12.0	4.2	0.0	2.2	—
Work ethic	6.9	11.3	9.5	10.8	7.5

Percentages do not total 100 as multiple answers could be given to this question.

informal consultations with colleagues and self-referrals to specialists. Doctors also reported difficulties taking sick leave, related to their reluctance to admit to illness and to create extra work for colleagues who would be required to cover their absence. Sick leave was especially difficult for GPs in single-handed or small practices and those without adequate insurance for locum cover.

Four of the 24 doctors with clinically diagnosed psychiatric illnesses took no sick leave at all, and another three had some episodes of depressive illness during which they continued to work. A consultant with Bell's palsy reported, 'I wasn't able to do my anaesthetist duties simply because I wasn't in a position to talk to patients ... but I still found myself having to come in each day to make sure that things were okay on the intensive care unit ... I realized I'd have been better off at home, but there really didn't seem to be any alternative but to come in and look over the unit.'

In two cases, informal consultations with colleagues resulted in the individuals not being diagnosed and continuing to work although they were unwell. Another GP with a depressive illness reported that his opinion about his fitness for work and need for medication was repeatedly sought by his treating doctor. 'Obviously one doesn't like to think that one is ill enough to require treatment and therefore you say "well, I'll see how I go for a week or two"' and it is possible to carry on for nearly six months saying that, despite the fact that you're getting increasingly ill and unable to work properly.'

Several doctors returned to work earlier than they might have advised a lay patient to do, and others reported overt pressure to do so from colleagues. Some doctors also commented that their treating doctor failed to give them guidance about whether sick leave was appropriate or how long a period was warranted.

Discussion

As expected, both professional groups reported low levels of sickness absence. Expected gender differences were also found: female respondents reported more absence than males but only in the case of hospital doctors was this difference statistically significant. We controlled, albeit crudely, for morbidity by assuming that both occupational groups had a similar health status, related to their similar socio-economic status, and by adjusting for age and gender, yet doctors reported taking significantly less sick leave than the fee earners. When the doctors did report an absence, it was significantly more likely to be a long spell. Similarly, Pines *et al.* (1985) found that the mean duration of absence reported by doctors was higher than that of other hospital employees.³ The lower response rate achieved for the fee earners means that some caution is warranted. However, we are reasonably confident in the representativeness of the data, as employees in this category have been shown elsewhere to take less than average sick leave.¹

Table 5 Response to hypothetical question: 'If you woke in the morning with a streaming cold and a headache would you take the day off work?', percentage by professional group

	Hospital doctors				Company fee earners (n = 241)
	GPs (n = 532)	Juniors (n = 254)	Consultants (n = 215)	All (n = 506)*	
Yes, definitely	0.7	0.4	3.3	1.7	2.9
Probably	1.7	4.3	3.3	3.7	12.6
Possibly	9.8	39.0	35.7	38.1	53.3
Definitely not	86.6	56.3	57.8	56.3	31.9

* Includes 37 hospital doctors who gave no information about their grade.

Nearly all survey respondents reported 'working through' illness on occasion, although doctors appeared less willing, or able, to be absent from work for a minor condition. The qualitative data confirm the survey finding of organizational and cultural barriers to sick leave, illustrating how one set of factors reinforces the other. For example, awareness that an absence will lead to increased workload for colleagues may produce feelings about imposing a burden on them. The fact that the same barriers were reported by doctors whose illnesses were not trivial suggests that the way doctors deal with minor illness may influence how they deal with more serious conditions. Whether for a minor or serious complaint, doctors find it difficult to adopt a patient role, which includes sanctioned absence from work.¹³

Comparable qualitative data were not collected for the company fee earners but personnel managers interviewed in preparation for the study suggested that 'giving in' to illness may also be perceived as weakness in this group, especially for those in training. The importance of demonstrating commitment to the organization by working during 'private' time has been reported by graduate accountant trainees.¹⁴ It is plausible that working through illness may also be seen as desirable for this group.

The differences in rates of sickness absence between the two professional groups may be attributed to a number of factors. The company fee earners might have higher rates of morbidity, although there is evidence to suggest possible higher than expected levels of psychological ill-health among the doctors.^{8,9} Alternatively, the fee earners might be more likely to be reporting absences for non-medical reasons. Such an interpretation is consistent with standard approaches to sickness absence which argue that this cannot be equated with morbidity as its causes may be social, psychological or personal, rather than medical.¹⁵⁻¹⁷

This paper, however, offers an alternative interpretation. Where most research has focused on factors leading to elevated rates of sickness absence, we suggest that factors such as attitudes to illness and working conditions may lead to artificially low rates of absence. Doctors may be more reluctant than the comparative group to adopt the patient role, reflecting differences in the culture of work; or the nature and organization of the work itself may create barriers to sick leave. Company fee earners may have greater flexibility in organizing tasks to meet deadlines, 'postponing' sickness absence and taking work home when unwell.

One effect of the focus of much research has been implicitly to cast sickness absence as an abuse of entitlement, or malingering. By contrast, data from the Whitehall II study suggest that sickness absence may indeed provide a measure of health if this is understood in the broadest sense of physical, psychological and social functioning.¹⁸ Failing to attend work, it is suggested, indicates impaired functioning, whether physical, psychological or social. But it cannot be argued that attending work necessarily indicates unimpaired functioning.

Most studies have failed to consider low rates of absence, although Taylor found that 28 per cent of workers who never took sick leave had some organic disease.¹⁹ 'Working through' illness has not been widely investigated but has been documented in occupational groups other than doctors, but with fewer respondents reporting that they did so.^{20,21} High levels of occupational stress are being reported in many employment sectors, which could lead to increasing rates of sickness absence. Yet economic uncertainty and changes in working practice might also serve more generally to discourage employees from taking sick leave.²² Absenteeism programmes which reward full attendance imply that employees who take no sick leave are to be emulated, even though such attendance is not of itself indicative of an absence of morbidity nor of 'functioning'. Such strategies not only overlook the social determinants of health beyond an individual's control but may also encourage health behaviour which could be harmful to individuals and the quality of their work.

It is clear that doctors' tendency to work through illness has implications for the quality of care delivered by those who continue to work while unwell. The relationship between doctors' health and patient safety has been recognized, although few quantitative data are available.^{23,24} The doctors interviewed for the qualitative part of this study, who worked rather than take any sick leave, expressed concern about their own performance. In any case, eliminating barriers to doctors' sick leave would not only enhance the management of doctors' own health but also contribute to strategies to ensure the quality of patient care.

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