The language of work disability

A study of medical certificates written by Norwegian general practitioners

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Guri Aarseth

Department of General Practice
Institute of Health and Society
Faculty of Medicine
University of Oslo
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‘Here I sit and govern [...] with my pen. I write, and it is done’

King James IV of Scotland, 1603
Abbreviations
DB: Disability benefit
GP: General practitioner
HELFO: (Helseøkonomi-forvaltningen) Administration of Health Economy
NAV: (Arbeids- og velferdsforvaltningen): Norwegian Labour and Welfare Administration
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Summary in English

**Background:** About 10% of the Norwegian population between 18 and 67 years of age receive disability insurance. Norwegian general practitioners (GPs) are required to act as experts in matters relating to disability insurance and rehabilitation benefits. From 2012 to 2017, GPs provided almost 98% of all medical certificates of work incapacity for the Norwegian Labour and Welfare Administration (NAV) (personal e-mail report from the Administration of Health Economy, HELFO). Accordingly, we must assume that GPs have a strong influence on the distribution of welfare benefits in society. Several surveys and interviews have drawn attention to GPs’ experience as experts on behalf of their own patients, and studies of NAV officials’ assessments of medical certificates have been conducted. However, we have very little direct knowledge of the content and quality of these medical certificates. This thesis is based on document analysis of 33 medical certificates related to work incapacity.

**Aims:** First, to investigate how the certifiers present and describe the patient as a person and participant in the social security scheme. Second, how they, in their texts, explain illness and how it relates to reduced function and work capacity. Third, to explore the values and attitudes that GPs emphasise in the certifiers’ texts and what kinds of rhetorical strategies they use when addressing their readers.

**Methods:** Qualitative document analysis using methods of linguistics, literary criticism, and narratology.
**Purpose:** To provide direct knowledge about a selection of medical certificates of work incapacity written by GPs.

**Main results:** In the certificates, the focus is on symptoms and disease and to a lesser degree on the patient as a person. The patient is frequently not discernible as a person in the text, but is predominantly described as a passive carrier of symptoms. Their ability to act is described as low or non-existent, and they are passive objects for the actions of other anonymous actors. In contrast, the symptoms are emphasised as independent and strong actors. The patient’s experience with illness is sometimes reported, but the GP’s perspective is usually doctor-oriented rather than patient-oriented.

The medical information is partly unclear/inadequate, sometimes ambiguous, and sometimes inconsistent. The reason for the patient’s work incapacity is unclear in most of the texts. In some medical certificates, a subtle use of language insinuates doubt about the patient’s credibility or real work ability. Detailed assessments of the patient’s working conditions or work ability are rarely reported. The texts use a variety of persuasive strategies. Some emphasise the patient’s positive character and attitude, which we take to mean that the patient “deserves” disability benefit or is a worthy applicant. Others appeal to the reader’s compassion, understanding, and helpfulness and to the reader’s willingness to be realistic or pragmatic and to grant disability payment. The voices in the texts construct authority primarily by marking their subjective stance or, more objectively, by speaking with “the voice of the profession”. All of the medical certificates in our sample, directly or indirectly, support the patient’s disability benefit. The texts can be seen as the “place” where two conflicting considerations meet – on the one hand, there is the physician’s deeply rooted, professionally based patient loyalty, and on the other hand is the physician acting as the gatekeeper who is supposed to ensure that nobody other than the worthy needy are supported by society. It is likely that the often negative experiences of physicians in dealing with this role can be expressed in the form of vague, incomplete, or normative texts.
Norsk sammendrag


Hovedmål: For det første, å undersøke hvordan fastlegene fremstiller den uføresøkende pasienten som person og deltaker i trygdeprosessen. For det andre, hvordan fastlegene i sine tekster forklarer sykdom og på hvilken måte den har ført til arbeidsuførhet. For det tredje undersøker vi hvilke verdier fastlegene legger vekt på i sine tekster, hvilke holdninger de selv formidler og hvilke retoriske virkemidler de bruker overfor leseren.

Metoder: Kvalitativ dokumentanalyse som benytter metoder fra lingvistikk, litteraturkritikk og narratologi.

Studiens formål: Å frembringe direkte kunnskap om et utvalg legeerklæringer ved arbeidsuførhet skrevet av allmennleger.

Hovedfunn: I legeerklæringene er fokus på symptomer og sykdom, og i mindre grad på pasienten som person. Pasienten er ofte ikke til stede i tekstene og blir hovedsakelig fremstilt som passive bærere av symptomer. Tekstene beskriver
deres aktør-status som lav eller ikke-eksisterende, og fremstiller ofte pasientene
som passive objekter for anonyne aktørers handlinger. I motsetning til dette blir
symptomene vektlagt som uavhengige og sterke aktører. Pasientens erfaring med
sykdom blir noen ganger rapportert, men legens perspektiv er doktor-orientert
snarere enn pasient-orientert. Den medisinske informasjonen er delvis uklar eller
utilstrekkelig, av og til tvetydig og noen ganger inkonsistent, og årsaken til
pasientens arbeidsuførhet kommer ikke klart frem i de fleste tekstene. I noen
legeerklæringer finner vi en subtil språkbruk som kan antyde tvil om pasientens
troverdighet eller reelle arbeidsevne. Detaljerte vurderinger av pasientenes
arbeidsforhold eller arbeidsevne blir sjelden rapportert. Forskjellige
overtalelsesstrategier anvendes. Noen tekster legges vekt på pasientens positive
karakter og holdning, hvilket vi tolker som at pasienten «fortjener» uføretrygd,
eller er en verdig søker. Andre appellerer til leserens medfølelse, forståelse og
hjelpsomhet og vilje til å være realistisk eller pragmatisk og tilstå uføretrygd,
trolig for å tillegge leseren et medansvar. Tekst-stemmene bygger autoritet ved å
markere sitt subjektive standpunkt eller, mer objektiverende, ved å «bruke
profesjonens språk». Alle legeerklæringerne i vårt utvalg støtter – direkte eller
indirekte – pasientens ønske om uføretrygd. Tekstenes kan ses som «stedet» der
to uforenlige hensyn møtes: på den ene siden den i legeyrket dypt forankrede
pasient-lojaliteten, på den andre siden den pålagte portvokter-rollen som skal
hindre at andre enn verdig trengende slipper å forsørge seg selv og i stedet blir
understøttet av samfunnet. Det er sannsynlig at legers ofte negative erfaringer
med å håndtere denne rollen kommer til uttrykk i form av vage, ufullstendige
eller normative tekster.
List of papers


Paper 3: Guri Aarseth, Bård Natvig, Eivind Engebretsen and Anne Helene Kveim Lie:
Acting by persuasion; values and rhetoric in medical certificates of work incapacity; a qualitative document analysis. *BMJ Medical Humanities* Sep 2018.
1 INTRODUCTION

‘Writing is inherently difficult. The readers are unknown, invisible, inscrutable; they exist only in the writer’s imagination. They aren’t there to break or ask for clarifications. This means that (...) writing is an act of craftsmanship’.
Steven Pinker.

1.1 Why study medical certificates?

In 2014, a woman made a complaint about a physician to the Medical Ethical Council, saying that she, after having read the medical certificate written by her family doctor, had lost all her confidence in the medical profession. What had offended her was the GP’s description of her; according to this, she neither had any work capacity, nor residential ability, nor ability of social functioning. Furthermore, she was described as having little adaptability and as being unable to concentrate. Her disabilities were life-long, and there was nothing to do about it. Furthermore, the GP had noted that the patient should not get access to the certificate’s content because she might be offended and it might have a negative impact on the doctor-patient relationship (which was claimed to be good). In his statement to the Council, the GP emphasised that he had tried to be objective, and ‘as little as possible being coloured by the patient’s subjective view’. The report from the Medical Ethical Council quotes the complainant (after she had read the GP’s statement) saying that she ‘…has completely lost her trust in the medical profession’ (Council, 2014: 13).

In this particular case, the text touches upon not only issues such as the concept of “objectivity” vs. the subjective voice of the patient, but also the textual authority adopted by the writer, and – eventually – the appearance of an unintended reader, the patient.

While we might wonder why the GP would deprive her of central abilities, or why he had not included the patient’s ‘subjective view’ in the certificate, the
report might serve to remind us that such a text is a social action; once in the hand of the reader, it implicitly commits itself to a truth or reality, a construal that may or may not be shared by the reader. In addition, the reality described in the texts justifies important decisions with great consequences to individuals and society. It is for these reasons that we wanted to study medical texts in the form of medical certificates.

Producing texts is a substantial part of medical practice; nevertheless, medical texts in general and medical certificates in particular are paid little attention by the medical community. Texts are ubiquitous within all fields of medicine, and written documentation might be the only proof of the physician’s medical skills and practices. Likewise, in research the primary goal is the text – the scientific article – by which the project is assessed and ranked.

The physicians’ texts are not only tools for the profession, representing medical and sometimes other kinds of knowledge of the patient and documentation to society, but are also the tool by which physicians function as gatekeepers. They influence the distribution of social benefits, directly or indirectly, they open doors to treatment, and they provide access to (or prevent) economic compensations. Medical certificates of work disability, in particular, are social actors with a unique impact on public costs and with great consequences to the health and economic safety of the individual. Even though they form the textual basis of important decisions without the decision-makers ever meeting the patients face to face, we know little about these documents. Providing knowledge about the textual character of these documents is therefore the aim of this thesis.

The expert’s discretionary assessment of a person’s health and work ability gives the premises for decision-making but is not part of the civil service as such. Biased or deficient certificates might conflict with fairness and reason on a social and individual level, but unlike failure or inappropriateness of a physician’s clinical practice, they rarely lead to any negative consequences for the certifier. GPs are expected to make statements about work capacity without being particularly educated to do so and to issue medical certificates without any
particular education in how to write them. Existing ethical and legal rules are practical guides, but they cannot replace proficiency in text writing.

This thesis is based on a three-part study of medical certificates of work incapacity written on the NAV’s standard form, and it is the first systematic research on the rhetoric of medical certificates in Norway. Through an in-depth textual study, we set out to investigate the texts of certificates assumed to be representative of the ordinary texts of doctors in usual practices of family medicine written about “usual” patients who claim to be incapacitated for work. Our text analysis focuses on three aspects of the medical certificates – firstly, how the patient is construed as a participant in the process that might or might not end in the granting of disability benefit (DB), and secondly, how the medical certifiers explain connections and causal relations of illness, functionality, and work capacity, and, eventually, whether and how the certifiers forward attitudes and values and how they address and communicate with their intended readers.

2 PRIMARY AND SECONDARY RESEARCH OBJECTS

Primary research objectives: To acquire empirical knowledge about the language in medical certificates of work incapacity.

Secondary research objectives: to investigate 1) how GPs, in their texts, represent the patient as a person and participant in the process of disability benefit, 2) how GPs explain illness and how it relates to reduced function and work capacity, and 3) the values (other than illness) and attitudes emphasised in the certifiers’ texts and the rhetorical strategies used toward their readers.

3 SITUATING THE STUDY

This project arose in the intersection of three realms: the text, medicine/the physician, and the welfare system. It is a specific variant or sub-genre of the medical text that is our study object – the medical certificate. Although it is a separate text genre not written for the purpose of clinical work, it continues to some extent the legacy of the clinical medical texts. In addition, we should see
the medical certificate in light of the welfare state’s statutory understanding of illness and the demands it attaches to the person claiming to be work disabled. Situated in the intersection of these considerations, the medical certificate is a relatively new genre within the history of medical discourse.

3.1 Historical context: medicine in the 19th and 20th centuries
Medical texts comprise the writings of medical practices exerted by individual physicians toward individual patients in the form of patient records, referral letters, discharge letters, and a variety of expert certificates. In addition, they include scientific articles, editorials, textbooks, case reports, and popular medicine. Medical texts, since the time of Hippocrates and further ‘throughout centuries, reflect diagnostic practices and changing theories of health and disease’, the professional-patient relationship, and the ‘weightings accorded subjective and objective factors in the medical assessments of illness’ (Hurwitz, 2006).

The self-consciousness of the medical profession of the Parisian School of the nineteenth century, as described by Michel Foucault, was due to the making of a new language that was not so much related to treatment of the sick person as to the new medical terminology. The new classification systems of the Parisian School, as Michel Foucault puts it, were the sources of the language that authorised medicine in the eighteenth and nineteenth centuries (‘one now sees the visible only because one knows the language’) (Foucault, 1989). The new terminology was based on the what Nicholas D. Jewson calls ‘the four great innovations’ of the Parisian School: the nosology, the pathology, the physical examination, and the statistical analysis (Jewson, 1976). From the perspective of the symptom orientation of the bedside medicine practiced in the patient’s home, the body, now three-dimensional (symptoms, signs, and pathologies), was moved into the hospital’s neutral, undisturbed room, gradually becoming the object of study and the new inventions of inspections, percussions, auscultations, and palpations. In the Parisian hospital schools of the nineteenth century’s early decades, Nicholas D. Jewson notes that the sick man became ‘a collection of
synchronised organs, each with a specialised function’. The (Parisian) hospital medicine and the (mainly German) laboratory medicine, Jewson claims, contributed to reducing the patient from a person to a case and eventually by laboratory medicine to a complex of cells (Jewson, 1976). Jewson’s outline is one of the many critical voices arising in the last half of the twentieth century against what they saw as a dehumanising and alienating hospital power.

The failure of a narrow biomedical model of disease was pointed out by the psychiatrist Georg Engel in his now classic article announcing that ‘all medicine is in crises’. Medicine, Engel claimed, adheres to ‘a model of disease no longer adequate for the scientific tasks and social responsibilities of either medicine or psychiatry’. He considered the ‘biomedical dogma’ that gave way to the modern clinic to be reductionist, insufficient, and driven by ‘the power of vested interests’, while ignoring the social, psychological, and behavioural dimensions of illness (Engel, 1977). Engel’s launching of the bio-psycho-social dimension of medicine was a response to the psychiatric profession’s fear of not being included in the ‘[bio-]medical model’, but also to those who saw mental illness as ‘a myth’ that should not be classified as medicine, but as ‘problems of living’. To this, Engel claimed, the dichotomy between diseases and problems of living is by no means a sharp one, neither for the patient nor for the doctor (Engel, 1977).

The criticism of the Cartesian doxa that sees the body as a de-animated machine was supported and extended to include yet another dimension by the psychiatrist and medical anthropologist Arthur Kleinman. His division of disease and illness pointed to the gap between biomedically explained disease on the one hand and that of the cultural perception of disease, the sick person’s behaviour, on the other. Kleinman defines disease as abnormalities in the structure and function of body organs and systems, whereas illness refers to the human experience of sickness (Kleinman et al., 1978). While disease is explained by medicine as biological malfunctions, Kleinman sees illness behaviour as culturally shaped and learned ‘approved ways of being ill’ that vary with one’s social positions within the boundaries of ethnicity, class, and families.
3.2 Medical text genres and their functions

Although medical text genres might have more in common than what separates them, there are some linguistic and rhetorical patterns characterising them, mainly due to their different purposes.

3.2.1 Texts constructing medical knowledge

Mina Vihla speaks of a ‘division of labour’ between the genres of medical writing (Vihla, 1999). In a large text corpus, he investigated how medical genres, among other things, are characterised by differences in the use of modal verbs. In constructing knowledge, they express degrees of possibility and probability of truth (something is → may be → is not), which is referred to as epistemic modality. Likewise, they are concerned with the norms and morally responsible actions of the profession, using verbs that express degrees of necessity or inclination (must → must not; should → should not), which is referred to as deontic modality.

Vihla argues that medical genres make up a linguistically ‘functional hierarchy’ of certainty and necessity. Along a scale of increasing degree of certainty and necessity, he finds how knowledge is presented by research articles, editorial assessments, practical recommendations, and medical manuals – and beyond these the popular medical articles addressing lay readers. Hence, the scientific articles present their hypotheses with markers of hedging (“seem to”, “apparently”, etc.) and reservations (“if”, “presupposed that”, “possibly”, “might”/ “might be”, etc.) against claims of truth. In medical articles, the use of epistemic modality expressions (certainty and probability) is, among other things, related to reliability; the use of hedges and modalities indicating likelihood not only increases the argumentative force of the article, but shows that the writers do not present their results uncritically (Vihla, 1999). The medical editorial typically assesses scientific articles using epistemic probabilities (a bit closer to certainty than mere possibility), whereas medical manuals contain ‘abundantly deontic modals’ to promote how medical knowledge ought to be practiced in the clinic. Finally, the scientific textbooks – making up the top of the modality pyramid – use mainly categorical statements. Likewise, popular medical texts,
Vihla points out, are predominated by deontic modalities, particularly connected to the extension of medical power to define life problems and how to solve them according to a medical template (Vihla, 1999: 133-134).

3.2.2 The illness story and the case report
The clinical case report is a medical text genre that has been used for centuries. Traditionally, it usually contains the illness story, the physician’s observation, sometimes the treatment, and eventually the course of the disease. Reflecting the changing diagnostic practices, ideologies, and concepts of disease and health over time, their importance lies in their didactic functions ‘intended for a wider audience that has neither seen nor attended the sick from whom they arise’ (Hurwitz, 2006). In her essay about dysmenorrhea and menstruation, Anne K. Lie describes the illness story as ‘the core of medical theory and practice in the nineteenth century’ and ‘central in the production and administration of medical knowledge’ (Lie, 2012). Selected and written down by physicians, their authoritative interpretation of symptoms and their causes had a didactic purpose, and beyond that, they functioned as scientific arguments justifying and supporting cultural and ideological constructions.

In the nineteenth and twentieth centuries, the importance of the case report, and with it the illness story, declined in favour of physicians’ direct access to the sick organs, a trend made possible by medical technology and the laboratory. Now, the separation of the “objective” from the patient’s “subjectivity” changed the status of the patient and the doctor-patient relationship. The patient became increasingly depersonalised, and the doctor became increasingly detached in the reports. Case reports of today are generally marked by an anonymised physician and the depersonalised patient as a passive object, linguistically presented in passive voice underscoring their lack of agency (Hurwitz 2006).

The modern case report, a condensed description of a sick person’s situation, usually presents the whole course of the disease including signs, symptoms, anamneses, technical findings, treatments, their effects, and the outcome either as recovery or death (Taavitsainen and Pahta, 2000). The ancient, Hippocratic,
detached description of the symptoms and signs can be recognised in modern case reports (and other types of medical texts), but now supported by rich details of techno-chemical findings that emerged during the hospital spatialisation of illness (Armstrong, 1995), or what Jewson called the extracorporeal knowledge of laboratory medicine (Jewson, 1976).

The case report – from Hippocratic writings to the early years of the twentieth century – has become a more specialised subgenre in our days, with linguistic features similar to the scientific article and appropriate to be presented to a global public of medical colleagues (Taavitsainen and Pahta, 2000). Kathrine Montgomery describes them metaphorically as medicine ‘from the field’ or ‘from the trenches’ (Montgomery, 1991: 93). The didactic meaning of the illness story is its role as an example of the typical (Lie, 2012), but it might well also work as a reminder to colleagues that individual, rare manifestations of “ordinary” diseases occur and that they can learn from them (Taavitsainen and Pahta, 2000). Case reports can, for instance, be found in every edition of the *Journal of the Norwegian Medical Association* under the heading ‘Noe å lære av’ (‘Something to learn from’). Though mostly stripped of everything else but relevant medical information, modern case reports do not omit the narrative, dramatic tension found in older case reports of the eighteenth century (Hurwitz 2006). They are written in the light of hindsight, long after the event, as an edited version produced after the case problem has been understood and solved (Hurwitz, 2017). In hospitals, it is usually the narrative of a team, but still with only one voice representing a coherent we. The “we”, according to Montgomery, is a convention of the genre that conceals the subjectivity of the single physician’s perceptions, making the case neat to the reader (Montgomery, 1991).

Frequently used in medical schools, the case report also has a socialising effect. Kenny et al. investigated the language in case reports used in PBL (problem based learning) in a medical school (Dalhousie University, Canada) attending to the values and attitudes they (implicitly) mediated. The authors concluded that the case reports revealed underlying assumptions, values, and attitudes and that the privileged medical perspective along with the rhetorical
structures that depersonalise and devaluate the patient is part of the socialisation of students into the medical role that might contribute to the erosion of ethical sensitivity (Kenny and Beagan, 2004).

3.2.3 The patient record: The narrative gap

The site at which the patient’s identity is most immediately realised is when the person is positioned through the transmission of medical knowledge (Macdonald, 2002). This ‘transmission’ has been the object of linguistic, sociological, philosophical, and literary approaches. Rita Charon, professor of medicine and a literary scholar, has stated that the communication problems between the doctor and the patient are not superficial, but represent an intersubjective gulf between two cultures of language. The doctor’s language (belonging to that of the Enlightenment epoch) aims to control and enclose, whereas the patient’s language (that of the Romantic epoch) is used to express feelings, question, and to guess about causal factors (Charon, 1992).

The distance between the two languages (and stories) of the patient and the doctor is the main theme of Kathrine Montgomery’s now classic report from observations in a hospital (Montgomery, 1991). The representation of the patient in medical records, Montgomery states, is based on a primary story that is the patient’s own, but one that the medical discourse aims to control and strip of the personal and subjective in order to achieve an objective and medically recognisable account of disease. To replace what she denotes as physicians’ ‘intellectual colonialism’, Montgomery states that the patient record cannot be seen as an objective, neutral, scientific report, but as a human and humanly constructed account, and neglecting it is tantamount to therapeutic failure (Montgomery, 1991: 125).

Much of the critique toward the medical discourse has a narratological approach. Practitioners and theoreticians see narrative medicine as a lever to the humanisation of hospital medicine (Charon, 2006; Flood and Soricelli, 1992a) and the patient’s own narrative as a basis of effective treatment and healing (Frank, 1995; Montgomery, 1991). Montgomery launched the concept of the patient as a text deliberately connoting the physician as a reader or interpreter of
this “text” in the medical encounter. Narrative interactions between the patient and the physician, Montgomery suggests, depend on the physician’s careful and sincere return of the story to the patient, acknowledging that no medical story is a life story (Montgomery, 1991: 141).

Rather than taking the patient’s history, the doctor might act as a receiver of it, which calls upon the narrator’s humility (Marshall and Bleakley, 2013). The authors see the encounter between the patient and the doctor as a translational interaction, a process of negotiation of meanings. There is not only the problem of “translating” the patient’s language into the language of the doctor, but also translating between different medical actors without the patient’s source text being lost in translation.

Marc Berg finds that case histories and patient trajectories constructed as narratives in hospitals are summarised, stylised, and reconstructed in accordance with the internal procedures of the hospital. The physician distils, selects, ignores, and reconstructs information from different points of time and places, with different relevance, putting it into one single frame that is well adapted to the agenda of the hospital, while at the same time transforming ‘the patient’s body into an extension of the hospital’s routines’ (Berg, 1996).

If the patient is subjected to the routines of the hospital, the hospital as an institution is subjected to trends and ideologies of history. The shifting routines and cultures of a hospital and their effect on physicians’ clinical writings are visualised by Petter Aaslestad in his close reading of psychiatric patient records written over a time span of one hundred years (1890–1990) in Gaustad asylum in Oslo (Aaslestad, 2009). In his analysis of the patient records, Aaslestad reads with the ‘hermeneutics of suspicion’ (page 64), reflecting the idea of language as a means of power. Aaslestad takes as a starting point that ‘all medical records are essentially narrative in structure’ (page 8). His research focus is the story about the patient and his illness, not the patient and his illness. He notes how the changing and at all times predominating medical-scientific discourse and ideological trends over the century influence the encounter between the doctor
and the patient. There are strong traces in the records of the loyalty to these ideologies.

From this perspective, the texts are studied vigilantly in order to oppose and fight bureaucratisation and depersonalisation (Engebretsen, 2007). Engebretsen’s narratological approach provides access to the (perhaps often unintended) manipulative language in the records, for instance, by implicatures (the underlying meanings), inferences (the reader’s interpretations of the unsaid), summaries of events obscuring details, and conflations of voices. The author argues that more consciousness of language will not necessarily improve the writing abilities of the officials, and neither is complete control of language feasible, with all its denotations and connotations. Manipulative language is ubiquitous, and introducing too detailed guidelines for record writing will, most probably, enhance bureaucracy, Engebretsen argues. He proposes the use of deconstructive reading (and, like Aaslestad, the hermeneutics of suspicion) to increase the reader’s critical competence (Engebretsen, 2007).

3.2.4 Patients’ language and narratives
Within qualitative research on patients’ experiences, participants’ narratives about living with certain diseases have come into focus, especially as a source of knowledge about lived pain in invisible illness and illness without any known organic correlates. Pain metaphors used by women with fibromyalgia were mapped in a Swedish study (Soderberg and Norberg, 1995). The most common metaphorical expressions used by the patients indicated an aggressive physical deformation like having a screwdriver turned into one’s body, feelings of being burnt, boiled, arms cut off, and so on. Such metaphors are, however, rarely seen in medical texts such as modern case reports (where the patient’s voice is absent in general), medical certificates, or discharge letters, and this might indicate that the clinical setting with the doctor is not the appropriate scene for the use of such tropes or that they might be ignored or converted into a professional language of medicine.

Women with fibromyalgia studied in other qualitative projects also report the extra burden of having an invisible disease (Nettleton, 2006) and that the
diagnosis as such can be stigmatising and of little help when the patient realises that there is no cure (Undeland and Malterud, 2007). The fibromyalgia narratives have yet other dimensions that are often ignored in medical reports, as shown by Päivi Juuso et al., and they show that the women’s feeling of wellbeing is related to the ordinary things in life and are hardly distinguishable from those of everyone else, such as having control, feeling the power to do things in everyday life, having caring relations, friendship, not being pitied, and so on (Juuso et al., 2012).

3.2.5 The rhetoric of the medical scientific article

The medical scientific article has not escaped the attention of linguistic and narratological analysis. The idea of scientific, medical language as value-free, objective, and descriptive has been challenged by linguistic analysis displaying such articles’ complex use of language. In a quantitative analysis of the word-corpus of nine scientific articles in *BMJ*, written in 1996–2004 on different topics, Gabriela Rundblad studied the use of impersonalisation (Rundblad, 2007). The use of impersonalisation in scientific articles is well known, and has the function of obscuring the authors for the purpose of generalisation. Generalisation is connected to objectivity and falsifiability (anyone could have come to the same results by using the same methods) and to increasing the authors’ reliability. In addition, replacing themselves by metonyms such as ‘interviews’, ‘tables’, and ‘essays’ also works to make the authors invisible (and less subjective), and metonyms can be used to reduce rival researchers who are not taking part in the study in question to ‘previous research’, ‘recent audits’, etc.

Expressions of politeness are a tradition in the writings of science, and in a wider sense they are used to construct hierarchies of prestige. Greg Myers has shown that politeness theories in speech apply to scientific texts as well. Politeness towards fellow – and competing – researchers and towards the reader is associated with verisimilitude, and modalities and hedges are a means of addressing the scientific community in order to mitigate claims and judgements (of others’ research) and to avoid infringement towards members of the community (Myers, 1989).
The use of metaphors within medical language was studied by Geraldine W. van Rijn-Van Tongeren (Van Rijn-Van Tongeren, 1997). She finds that metaphors taken from other disciplines and are extensively used even in biomedical research and understanding. The metaphors are not only shown to be clarifying and to have didactic power, but also to be constitutive of scientific thinking. This is, among other things, famously illustrated by Emily Martin in her article about scientific construal of human reproductive biology and the sperm and the egg. She showed that the researchers’ biological imagery of the germ cells and the metaphors they use to describe their functions are heavily influenced by socially constructed gender stereotypes in terms of masculine and feminine prestige and values (Martin, 1991).

The terminology and the descriptive, objective, and explicative style of a scientific text might obscure the texts’ normative, argumentative, or persuasive functions. In her thesis, K.R. Breivega exemplifies this by analysing a medical scientific article about transplantation of liver organs that uses a highly argumentative form as seen from a linguistic perspective – the use of evaluations/appreciations (good-bad), causal relations that are not completely and exhaustively explained, and finally, the use of declaratives (enunciations) without qualifications or references (Breivega, 2003).

3.2.6 The illness biography

The notion of the cooperative, patient-centred ideal of today’s medical practice has expanded into the idea of health care as a market or quasimarket of consumerism, with individual users ready to criticise health services and systems that ignore the autonomy of the patient (Armstrong, 2014). Along with the idea of the market-oriented health consumerist, the increasingly critical voice of patients has been partly channelled into a new literary genre, the illness narrative. The academic criticism against a unilateral biomedical approach and the paradigm of the silent and pacified patient emerging from the middle of the twentieth century led to a patient-authored medical narrative, the “pathography”. What made this visible to a broad audience was the new texts being published as patients’ stories, illness narratives, or pathographies, ‘our modern adventure
story’ describing experiences of illness (Hawkins, 1999). The genre has in turn propagated a large and corresponding critique within academia, focusing on its literary qualities and narratological issues related to autobiographies, but also on illness, patient orientation, and existential problems connected to illness. Hawkins classifies the pathography into two epochs: those written in the 1960s and 70s and those published later. In the first epoch, published illness experiences were typically testimonials, focusing on the author’s feelings and thoughts and (usually) with a positive attitude toward medicine. The authors’ explicit or implicit aims were those of acting as a mirror or a model to the reader. At the end of the 1970s, the pathography changed in tone and intent, reflecting mistrust toward physicians and fear of hospitalisation (“angry pathographies”) (Hawkins, 1999: 4). Angry pathographies sought to share with the reader the writer’s negative experience with a de-humanised, alienating medical system and were frequently oriented toward alternative explanations of disease and alternative treatments. The dramatisation of illness experience drawn in pathographies, Hawkins says, ‘is no worse a distortion of reality than is the biomedical myopia of the case report’ (Hawkins, 1999: 13), and she points out that the pathography reminds us of the need to return the experiencing human being to the centre of medicine.

3.2.7 Against narrativity

Since George Engel announced the biopsychosocial approach to solve ‘the crisis of medicine’ (Engel, 1977), the predominating “positivist turn” has been increasingly countered, not only by medical clinicians and scientists, but also by the humanities. The critique has to some extent been predominated by claims of the therapeutic advantages and humanising impact of narrative medicine (Frank, 1995; Charon, 2006; Montgomery, 1991; Flood and Soricelli, 1992). Arthur Frank sees the patient’s ability to construe a narrative as a necessary process toward healing (Frank, 1995), and Rita Charon takes narrativity to be a necessary medical competence for the physician to see beyond the obvious and the evident, to ‘construct a wide and deep and varied differential diagnosis’ (Charon, 2006). However, life understood as the ‘logic of a narrative’ has come
under criticism for pretending to be universally valid for human beings (Woods, 2011). The philosopher Galen Strawson denies that narratives are the only way that people experience their lives, nor does he agree that narratives are essential to ‘a well-lived life or to true or full personhood’; in fact, he argues, the narrative norm might even be distressing and destructive in some clinical contexts (Strawson, 2004).

3.3 What is the GP’s role in welfare policy?

When a patient claims benefits for being work disabled, the GP must provide medical information, and this information is the main basis of decisions made by the National Insurance (NAV) (Lima and Nicolaisen, 2016). The necessary conditions for disability benefit on a permanent basis are defined in chapter 12 of the Norwegian National Insurance Act, which also legitimises the role of the GP as an expert in such cases. The necessary conditions for disability benefit are as follows (Folketrygdloven, 1997a):

- The claimant must have a disease (a diagnosis).
- The disease must be permanent or chronic.
- The disease must cause a permanent loss of functionality.
- The current disease must make up at least 50% of the factors causing work incapacity.
- The permanent loss of functionality must be the main cause of reduced earning ability on a general basis (for any work).

The concept of disease/illness is defined in § 12-6 as “dynamic”, that is, it must be ‘scientifically grounded and commonly acknowledged within medical practice’ (Folketrygdloven, 1997a).

Social and economic problems do not qualify for DB.

The “main cause” means that disease must be the major cause of the reduced functionality, implying that it must be of some significance. Work capacity must be impaired by at least 50% compared to the claimant’s previous grade of employment. Furthermore, according to § 11-5, the claimant’s age, abilities, education, work experience, and employment possibility are legal factors to be
considered when assessing the appropriateness of treatment and work-related measures (Folketrygdloven, 1997b)

There are 4,581 (as of May 2018) regular GPs in Norway (Helsedirektoratet, 2018), most of whom are self-employed physicians with an operating subsidy. Since 2001, primary health care in Norway has been organised as a list system regulated by legal rules (Fastlegeforskriften, 2012). The patients choose their family physician with the right to be given priority (over non-list patients) by their list doctor.

The processing of DB is initiated only when the GP has made such a certificate. The NAV has no statistics on how frequently they use specialists as experts, but the distribution of “L-codes” (payment codes used by GPs and specialists for writing medical certificates for the NAV) is an indirect measure. GPs use the code L40 and the specialists use L120. The mean annual proportion of additional specialists’ expert statements (based on payment codes provided by HELFO, the Health Economic Administration) is stable and makes up 2–3% of the total number of medical certificates for work disability, usually as an additional statement to the GP’s assessment (Figure 1).

Figure 1. Distribution of GPs’ and specialists’ L-codes (y-axis) used for issuing medical certificates of disability from 2012–2017. The numbers are given by the Health Economy Administration (HELFO).
Because about 98% of all medical certificates are written by GPs, their expert documents have great importance to the local NAV officials who prepare the cases for decision-makers on a regional level. The officials are not required to have any formal medical competence, which means that they must act on the basis of the information provided by the GP or must consult with the internal medical adviser at the office. The advisory physician might recommend that the NAV request a specialist statement. The causes for this vary, and they might be due to unclear conditions of illness, information about treatment options, inadequate GP information, and unclear medical certificates, among other things.

When a person, due to functional problems caused by illness, has become unable to earn a living through work, a number of welfare measures are available, including sick leave – fully or graded (for up to 52 weeks duration) – rehabilitation, work training support (since 2018, for a maximum of three years), and, eventually, permanent DB. The National Insurance Act presupposes that the disease is verified by the GP or a specialist and that the functionality might be assessed by a physician ‘or other health personnel’, for instance, by a psychologist. In addition, the NAV might ask for evaluations from its internal medical adviser. During the course of a long-term sick leave leading to an application for DB, a large number of the claimants have been examined and diagnosed by a private or hospital specialist. Discharge summaries frequently form part of the medical documentation of diagnosis and treatment, but are not obligatory, and they do not have the same status as medical specialist statements. A theoretical course from becoming disabled by disease to the granting of DB is shown in figure 2.
This is a patient’s potential course from sick-leave toward DB over a theoretical time span of about 4–5 years. At any point during the process, the claimant/patient can be reassessed by the NAV as being fit for full or part-time work and having the benefit withdrawn or reduced. In that case, the patient might either return to work if available or, if not available or if he/she still considers him/herself work disabled, apply for living support at the local social security office.

Gatekeeping is a term mostly associated with the physicians’ role, in particular the role as GPs. However, since the late 1980s the GPs’ role as the patient’s advocate in insurance medicine has been strengthened at the cost of the GPs’ gatekeeper function (Solli, 2007; Carlsen and Norheim, 2005). GPs’ gatekeeper responsibility is continuously under debate, reflecting their conflicting roles as the patient advocate, as the social system advocate, and, often, as part of a commercial business (Greenfield et al., 2016). Correspondingly, a
number of studies show that tasks related to gatekeeping are generally experienced by GPs as problematic, and some researchers suggest tools to cope with them, to which I return later in this text.

3.3.1 The NAV’s instruction to the GP

The National Insurance Act (Folketrygdloven) §21-4 delegates to the NAV the right to require health information about the patient.

The GP provides the patient’s illness story and the diagnosis and should evaluate *in what way* the illness affects the patient’s functionality and work capacity (NAV, 2017a). A medical *diagnosis* is obligatory, but the paramount issue is the patient’s capacity or ability to make a living by income *in spite of* a diagnosis. Some of the central points that must be addressed by the certifier are as follows (NAV, 2017a):

- A medical diagnosis. The diagnosis is not decisive though, and what is important is how the illness/disease influences the patient’s earning ability (the terms *work ability* or *work capacity* are not used).
- Describe, making the connection evident, the medical condition that has led to loss of function of such a nature and to such an extent that it constitutes the main reason for the reduction of earning ability.
- A time aspect: state from what point in time the patient’s income has been permanently reduced due to illness/injury.
- Describe the development of the patient’s disease, from the starting point until today. Focus must be on information that is relevant to this disease.
- What kinds of medical investigations and *treatment* were given, and what were the results? Did medical treatment improve the patient’s fitness for work?
- Describe and corroborate the limitations of the patient’s functionality as to performing various tasks in his/her previous/present work or other kinds of work, work training, daily life (house-work, etc.), leisure time, care, etc. The GP should also make suggestions about the patient’s possible future functionality.
The GP is not supposed to conclude whether the patient is eligible for DB, neither should he/she recommend or dissuade certain benefits. It is the NAV that makes the final decision of granting/not granting DB and mediates this to the claimant.

3.3.2 The NAV Medical Certificate for work incapacity (Legeerklæring ved arbeidsuførhet)

The currently used medical certificate of work incapacity of 1999 (appendices 1 and 2) is a three-page form used by the GPs. The form asks for extensive information about the patient’s diagnosis, illness history, treatment, prognosis, functionality, and work ability. In addition, measures other than medical treatment aiming at helping the patient to resume working must be considered by the GP. The form is used by GPs in cases of disease-related unfitness for work, whether this is temporary or permanent.

On the form, the GP must make clear the causal connection between the disease, the patient’s functionality, and the patient’s earning capacity. The physician is supposed to have insight into the patient’s work place and to describe actual work demands, type of work, and what the patient cannot do in the present job. The GP must suggest if treatment will ‘improve the work capacity’ and must suggest the ‘duration and prognosis’ of the disease, the loss of functionality, and the level of work incapacity.

An essential question on the form is: ‘Describe how the functionality is reduced in general due to disease’, implying that functionality is of greater practical importance than the diagnosis: having a disease is not a sufficient criterion; the disease must have led to reduced functionality to such an extent that the patient has lost his/her work capacity by at least 50%.

Section 8 allows for free text for optional, additional information. In section 10, the certifier may opt to make reservations against the patient’s access to (specified) information given in the certificate. The reason for such reservations must be “medical”, but need not be further specified by the GP.
3.3.3 Legal rules (Helsepersonelloven)

According to the Health Personnel Act (Helsepersonelloven, 1999), a certificate is ‘any written attestation, verification, evaluation etc. issued by health personnel’, excluding prescriptions of medicines (remarks to §2). Moreover, the legal remarks do not differentiate between a “treater’s declaration” and an “expert (sakkyndig) declaration”.

The Health Personnel Act §15 and its legal rule define and regulate health personnel’s attestations and medical certificates (Helsepersonelloven, 1999). The legal rule (2008) defines the content and quality requirements of certificates in general and states that a certifier must be ‘cautious, accurate and objective’ and that a medical certificate must be ‘correct and contain only information that is necessary for the purpose’. The legal rule provides a detailed list of the informational content (§4) that is required to make the certificate ‘complete and clear’. The information must be ‘correct’, that is, equal to a factual account (§3). However, correctness also includes the testifier’s evaluations of the factual account, that is, ‘professional evaluations’ must be in accordance with requirements of justifiability (§4). Correctness, then, involves consistency between the descriptive part of the statement and the assessments made, and between the assessment and the conclusions or recommendations that are given (Legal rules, §4). In the medical certificates that we have investigated, correctness is thus related to the causal connection between all the elements, including the patient’s history of illness and symptoms, the medical findings, the functionality level explained by the medical findings, and the work capacity of the patient.

3.3.4 Ethical rules

The ethical rules of the Norwegian Medical Association provide the ethical norms of expert certificates in general. Part I, general provisions, §2 (excerpt) states: ‘Doctors have different roles as treatment provider, expert and administrator of welfare benefits. […] A clear distinction must be made between [physicians’] roles of treatment provider and expert. Doctors are responsible for providing necessary information and appropriate information about their role and
the purpose of the contact’. Part IV §4 of the ethical rules sets the norms for issuing medical certificates and attestations: ‘A medical certificate shall convey sufficient information for its purpose and be objective and neutral in its wording. Relevant information must not be withheld or distorted. […] § 2: A doctor shall not issue a medical certificate if he/she is in doubt as to his/her competence. If a doctor does not find objective grounds for issuing a certificate, a certificate shall not be issued’ (Legeforeningen, 2015).

3.3.5 The certifying physician’s position within the politics of welfare

The physicians’ role as experts reflects the legal demand that a medical condition is a mandatory criterion for temporary allowances and DB. As stated in a report to Stortinget, ‘the GP plays a central role in clarifying disability pension’ and is instructed by the government to provide professional advice to the NAV on illness and work ability, how work capacity is reduced, and whether it is permanent (St.meld. nr.9, 2006-2007). The strong position assigned to Norwegian GPs as certifying experts (while acting both as family physicians and gatekeepers) has been questioned by the OECD (Organisation of European Cooperation and Development) who considers their dual role to be a threat to professional neutrality. The OECD states that there is a higher rate of DB receivers in Norway compared to countries that use formally independent medical experts to assess health and work fitness (OECD, 2010).

The Norwegian GPs’ position as expert within the Norwegian National Insurance scheme, however, has been remarkably stable ever since the National Insurance Act was enacted in 1967. Norway has, however, copied other countries’ reforms of welfare schemes, such as the fusion of social service offices and outsourcing of some of these services (job-training institutions) as in the UK (St.meld. nr 9, 2006-2007). The reforms aimed to implement and enhance the work-first policy to get more people into work and activity and fewer on social benefits (Prop.nr 46, 2004-2005).

Measures taken to reduce the number of individuals on benefits have hardly affected the GP’s role as certifier, but are directed mainly toward the claimants/patients through internal administrative re-organisations within the
NAV and new rules for implementing work ability assessment (Regjeringen 2010). According to the work-first policy, work capacity is not a matter of either/or, but should be adapted and graded in accordance with the patient’s medical condition.

The GP’s principal role as a certifier for the NAV has never been questioned so as to become a political issue. On the contrary, since the 1990s – due to the emphasis on medically based dysfunction, and hence work incapacity – the GP’s role as the most important provider of medical information has been officially strengthened. Among other things, measures were taken to counter what was termed the tendency of medicalisation of social and general life problems that increasingly were presented as “health problems” (St.meld.nr 39, 1991-1992).

Accordingly, the GPs were instructed to implement a new diagnostic system for primary health care, the ICPC (International Classification of Primary Care). ICPC-2 differentiates between symptom-related diagnoses and disease-related diagnoses, and the ICPC-2 diagnostic code must be included in sick-leave and medical certificates. The assumption was that the ICPC diagnostic manual would make the GP (and the NAV) distinguish more clearly between mere subjective illness (complaints and symptoms) and objective disease, ‘and [thus] separate health conditions of little significance to [the patient’s] work ability from the more serious conditions that could lead to permanent work disability’ (St.meld.nr 39, 1991-1992).

Diagnosis as the “admission ticket” to processing DB was thus maintained and even more heavily weighted, and so was the GP’s role as an expert. This, assumingly, would lead to limiting the influx of individuals to certain benefits and to consolidating the GPs’ position as medical certifiers. The restrictions seemed to lead some physicians to adopt new strategies. Among other things, a strategy was to go “hunting for” additional and relevant diagnoses to strengthen their patient’s cause, resulting in excessive use of health services to provide documentation and objectivisation – for instance, by more referrals to specialists and more diagnostic imaging – without knowing whether the findings could in fact explain the patient’s symptoms (Getz et al., 1994).
The isolated effect of the success or failure of “diagnostic discipline” is, however, difficult to assess. In fact, during the last decade there has been an increase in the number of people under 49 years of age who receive DB, though this is mainly explained by administrative reforms such as individual transfer from temporary allowances to permanent DB (NAV, 2017b).

The diagnostic turn was not the only point of regulation to delimit access to benefits. Along with restrictions of the admission criteria of health-related benefits, there was also a greater emphasis on the patient’s functionality rather than the mere diagnosis. A medical diagnosis remained mandatory for eligibility, but the question to be raised became, what can the patient perform in spite of the disease? Accordingly, a time-limited national insurance benefit, the ‘work assessment allowance’ (arbeidsavklaringspenger), was introduced by law in 2010 (Prop.nr.4, 2008-2009). It aimed at getting people with health-related work incapacity (reduced by at least 50%) into employment, spending more time on work-training and following-up on clients, and spending less time on “administering social benefits” (Regjeringen.no, 2010). In cases of work assessment allowance, the GP also has a central role in providing the medical terms for evaluating functionality, without which the patient cannot be assessed as eligible.

Medically based functionality assessment by the GP, however, seems to be the unspeakable issue in medical certificates. The lack of medically explained functionality assessments in the certificates is notorious and remains a usual complaint of NAV officials processing disability cases (Lima and Nicolaisen, 2016) and in reports remarking on the GPs’ role in matters of welfare benefits (St.meld.nr.9, 2006-2007; Steihaug og Hem, 2006).

The content and quality of medical certificates have for a long time remained a “secret”, explained by the fact that no systematic research on these texts has been performed. Lima and Nicolaysen point out how little attention is paid to the doctor’s medical certificates in the political documents (Lima and Nicolaisen, 2016). This stands in contrast to their importance for the distribution of social benefits and for the welfare of the individual.
3.3.5.1 The impact of the medical certificate on social economy

The GP is but one of several actors involved when a patient claims to be unfit for work on a permanent basis (which is usually preceded by sick-leave and procedures for general work assessment. The NAV’s processing of DB, however, cannot be undertaken without the documentation of one or more diagnoses and illnesses that lead to reduced work capacity. In almost every individual case a medical document is “the bottom line”, and we may take for granted that NAV officials will not proceed without a medical certificate from the list doctor. This is due to the obligatory health criteria stated in the National Insurance Act (Folketrygdloven §§ 8, 11 and 12) that make the diagnosis the “face value” and the key to these welfare benefits (but as we know, there are additional criteria).

We may take it that GPs’ certificates have great impact on the distribution of social costs, and altogether sick-leave and medical certificates of work incapacity issued by GPs legitimise the allocation of about € 16 billion (NOK 158.8 billion), which makes up 38% of the total national social costs (Figure 3) (Regjeringen.no, 2017).
Disability pension alone makes up 55% (NOK 86.5 billion) of all health-related benefits. This makes medical certificates central actors within the discourse of social justice. The National Insurance Act strongly emphasises the importance of the medical certificate in cases of health-related benefits, and it is regarded as essential to the NAV officials’ assessment of the patient’s work ability (Lima and Nicolaisen, 2016). However, politicians have paid little attention to the quality of these documents (Gjersøe, 2017) as is also the case in academia.

3.3.6 The medical certificate as a basis for decisions

The National Insurance Act emphasises the central importance of the medical certificate in cases of DB. When assessing temporary benefits in the outline of the patient’s work capacity, the medical certificate is decisive to the NAV officials (Lima and Nicolaisen, 2016). However, while information about the patient’s diagnosis is generally sufficient, the documentation of the disease prognosis and the patient’s functionality and work capacity are frequently considered by NAV officials as unclear and deficient (Lima and Nicolaisen, 2016). Still, in a world of many uncertain and vague factors, like working ability and functionality, the medical certificate draws attention to diagnoses and
diseases that might appear as the ultimate ‘certain within all the uncertainty’ (Gjersøe, 2017).

Most of the research on GPs’ subjective experience as certifiers is about sick-listing practices, and only a few studies have looked directly at the textual aspects and contents of medical certificates. These studies indicate that certificates of sickness – both short term and long term – are also often deficient or imprecise outside of Norway.

In a Swedish study of medical certificates of sickness, the authors found ambiguous medical information in one fifth of the cases and unclear assessment of the patients’ functionality in one third of the cases. The authors concluded that this limited the certificates as a basis for decisions regarding sickness insurance benefits (Soderberg and Alexanderson, 2005).

A SINTEF (Selskapet for industriell og teknisk forskning ved Norges tekniske høgskole) report on medical certificates of work disability concludes, among other things, that the medical certificate texts do not properly mediate the real insight and knowledge possessed by the GPs and are frequently unstructured and deficient. Among the evaluations they made of GPs’ certificates was that some of them contained scattered and casual information with little reasoning and that GPs more often than not acted as their patients’ advocates rather than as experts for the NAV. The SINTEF report also called for the certifiers’ evaluations of functionality and information about related contextual factors of the ill person, such as social, familial, and job issues. According to a range of quality scores between 0 (low) and 10 (high), most certificates were assessed to be ‘good’ (mean value: 5–6), whereas some were of low quality or ‘useless’ and some were ‘scandalous’ (Steinhaug og Hem, 2006).

In a Finnish study, medical certificates were considered ‘extremely deficient’ in 89% of the cases (according to the then strict medical criteria in Finland); however, they were all found to be accepted by the insurance as a basis for granting the patients free medication for the treatment of hypertension (Kekki, 1984). The author found that physicians extensively ignored obligatory medical
criteria, using more ‘general’ ones (not specified in the article), but were still approved by the insurance.

In a Swedish study, the social security court’s assessments of work capacity were investigated along with how GPs described work capacity in a selection of 45 medical certificates. The authors found that four out of five medical certificates had omitted descriptions of the patients’ general functional level and how it was related to their work capacity. The authors found little coherence between the court’s decision and the quality of the certificates, which could be inferred to be a mutual lack of understanding between “medical language” and “juridical language” (Mannelqvist et al., 2010).

In Sweden, Kiessling et al. found that information on work capacity was entirely adequate and relevant in only 10% of the certificates. Disturbed mental function was indicated in 60% of the certificates without a psychiatric main diagnosis. How the medical state influenced the functional state was not assessable in 19% of the certificates due to a lack of information. Similarly, whether reduced function influenced working capacity was not assessable in 27% of the certificates (Kiessling et al., 2013).

Social benefits related to health disorders make up a significant part of the Norwegian national budget, as illustrated in Figure 3. The most important documents for the NAV are the GPs’ medical certificates, without which there will be no processing of DB. We know that many GPs might find their expert task problematic, and this most probably has an impact on how they write them. There is, however, little systematic knowledge about the character and the quality of the documents that legitimise these social costs.

3.3.7 The dual role: the gatekeepers’ complex – blamed if they do, blamed if they don’t

GPs’ experiences with conflicting roles and demands have been studied across welfare nations. A review of articles based on studies in Great Britain, Switzerland, Sweden, and Norway concluded that a majority of GPs reported conflict as an overall theme, including conflict with the patient, with stakeholders, and with oneself with respect split loyalty (“the dual role”) toward the patient and
society (Wynne-Jones et al., 2010). The GPs perceived the doctor-patient relationship as conflicting with their current role as sickness certifiers. Accordingly, many of the GPs wished to relinquish their gate-keeper role (Hussey et al., 2003).

Conflicts with patients, sometimes leading to threats toward the GP (Nilsen and Malterud, 2017), patients with liberal attitudes toward sick leave, the physicians’ difficulties in assessing work capacity, lack of time and resources for treatment and rehabilitation measures, lack of external support, and problems with managing disagreement with the patient were reported as major problems in a large questionnaire in Sweden (Gerner and Alexanderson, 2009; Engblom et al., 2011; Swartling et al., 2008; Arrelov et al., 2007).

GPs report that their work with sick leave is even more disturbed by the new concepts of disease that they consider to be a medicalisation of social problems given names of ‘disorders’ entailing increasing pressure from patients with complaints such as fatigue and pain without medical explanations (Arrelov et al., 2007). In a survey conducted among Norwegian GPs, verifiability of diagnostic categories was reported as problematic, and verifiability of work ability even more so (Overland et al., 2008).

Gulbrandsen et al.’s investigation of Norwegian GPs’ experiences with acting as gatekeepers indicated that most GPs feel stressed by patients having ‘unrealistic’ expectations, but almost half of the GPs had ‘adjusted’ the medical certificate of work incapacity to help the patient obtain DB. The authors concluded that acting as gatekeepers can be experienced as a burden to GPs’ wellbeing (Gulbrandsen et al., 2002). Another Norwegian study suggests, likewise, that that GP’s low job contentment is in part related to patients’ behaviour connected to benefits (Getz and Westin, 1993).

Beyond the patient-doctor bond, macro factors such as economic and political structures might contribute to more client-oriented medical practices. There are indications that patient autonomy and an increasing consumers’ health market have long since changed the power balance between the physician and the patient (Armstrong, 2014). In a report evaluating the list system within primary care in
Norway, the authors conclude that the list system seems to have weakened the physicians’ judgements as gatekeepers (Norheim and Carlsen, 2003).

GPs might be inclined to avoid open conflict with the patient and thus might issue sick leave at the patient’s demand (Money et al., 2010; Gulbrandsen et al., 2007; Wynne-Jones et al., 2010), but this picture is modified in some studies. Money et al. found that GPs reported that issuing sick leave declined with the GPs’ increased competence in occupational medicine (Money et al., 2010) and by using negotiating strategies toward the patient (Nilsen et al., 2015).

In Norway, some GPs welcomed the restrictions of eligibility criteria that were put in place in 1991, but they also felt that the restrictions might threaten the patients’ welfare. This apparent paradox, after all, could be due to GPs feeling more comfortable with clearer roles (Getz et al., 1994). Others reported that the impact of the NAV’s restrictions on the GPs stand was insignificant, and they ‘recommended refusal’ in 9% of cases before (1990) and 8% of cases after the restriction (in 1993) (Claussen, 1999).

The GPs’ right to legitimise absence from work is not in accordance with their ability to assess work incapacity (Mannelqvist et al., 2010), and GPs commonly point to how little they know about work life and work ability assessment (Foley et al., 2012). Physical (dis)ability might sometimes be evaluated as “straightforward” with regard to functionality, whereas social and mental problems are seen as subjective or ambiguous (Brage, 2008). The connection between diagnosis and functionality in the questions of work ability is, however, not obvious due to the complex interplay between functional abilities and the GP’s incomplete knowledge of work demands (Brage, 2008).

4 THEORETICAL BACKGROUND

4.1 Theoretical considerations on professional judgement
There is little disagreement that physicians should act as their patients’ advocates. Unrestricted advocacy, however, might interfere with a fair distribution of health services and social goods and also infringe upon professional ethics of truthfulness and non-deception (Beauchamp and Childress,
This might well apply to the ethics of medical certificates. Sigurd Lauridsen argues that although unrestricted advocacy generates problems such as moral hazard, unfairness, and sometimes distrust, it continues to be important to the medical profession (Lauridsen, 2009). This contradiction is brought up also by Michael Lipsky who claims that doctors’ advocacy is incompatible with organisational perspectives for a variety of reasons (Lipsky, 1980: 73). One of them is that the organisation acts on the grounds that resources are limited, whereas the physician acts as if resources are unlimited, seeking to utilise loopholes and discretionary provisions to gain benefits for individual patients/clients (Lipsky, 1980: 73).

The authority of the medical profession, it is argued, is only legitimate when it does not expand its ethics into other fields with different ethical considerations (Beauchamp and Childress, 2013). The GP is an example of a performer with wide discretionary powers operating within fields that are in part in conflict with one another. Anders Molander argues that discretion is in tension with the formal demands of the rule of law, among other things, because it is not predictable; that discretion is in tension with the principle of equal treatment; that discretion might be based on extra-legal factors such as private beliefs and values, and, finally, that discretionary decisions have a tendency to blur the distinction between the public and the private, which might lead to ‘outright intrusion into the private lives of others’ (Molander, 2016). Accordingly, discretionary power might be exerted without democratic control. The tensions between discretion on one side and law and democracy on the other, Molander asserts, is intrinsic and cannot be removed; it can only be ameliorated. Because decisions on the distribution of welfare goods are concerned with individual cases, discretion neither can nor should be eliminated. It must, however, be based on accountability, that is, individuals should be able to account for their assessments and evaluations (Molander, 2016).

4.2 Documents as data material

This thesis is based on qualitative, stand-alone document analysis using different text-analysis approaches.
David Silverman defines “documents” (text and/or images) as data that were recorded without the intervention of the researcher, and ‘for this reason, textual data are, in principle, more reliable than observations’ (Silverman, 2014). Document analysis, as used in this thesis, puts into focus documents that have a particular impact on powerful institutions responsible for the distribution of social benefits. Decision-makers are not supposed to – and do not – meet the claimant face to face and mainly lean on GPs’ expert statements as the basis of decisions. In this respect, the document itself functions as a social actor (Atkinson and Coffey, 2011). The document analysis approach has as its starting point that documents are not accurate descriptions of social reality, but create their own realities. Documents are typically ‘recipient designed’, meaning that they reflect assumptions about – and thus anticipate – who will be the reader (Atkinson and Coffey, 2011) and are thus adapted to that readership.

A great advantage of documents as data that is often pointed to is that they are stable data and ready-made for the researcher. In addition, and as a consequence, the researcher has had no influence on their creation (Bowen, 2009). Reactivity, the direct effect of being part of the world the researcher studies, such as in interviews or participant observations, is a ‘powerful and inescapable influence’ that is usually not an issue in document analysis (Maxwell, 2005).

Document analysis has been relatively neglected within qualitative research in general (Murphy et al., 1998). Writing documents is a pervasive activity within all healthcare settings, but documents are still underutilised as research data within medicine. ‘This is a particular problem in settings such as hospitals and other treatment facilities, where written documentation plays a central role in the organisation of activities within the settings’ (Murphy et al., 1998: 129). We hope that our study of documents, the medical certificates, might contribute to upgrading documents as primary research data within medical academia.

Two main methodological issues are central in qualitative document analysis. Firstly, the frame of our analysis is a constructionist approach to documents as data. A constructionist approach aims at exploring not how social reality is, but how it is constructed and maintained. According to Holstein and Gubrium, the
constructionist approach is ‘(…) deeply concerned with what is done with
language to construct field realities (…)’ (Holstein and Gubrium, 2008: 375).
David Silverman underlines the rhetorical aspects of constructionism, that is, that
‘facts are socially constructed in particular contexts’ (Silverman, 2014: 26).
Consequently, documents are regarded as real data in their own right, not as
surrogates for other kinds of data (Atkinson and Coffey, 2011). Secondly, the
analysis of documents is an interpretational work because ‘documents, as other
forms of data, do not speak for themselves, but must be made to speak by the
analyst’ (Silverman, 2014: 277).

4.3 Theories of text analysis

4.3.1 Systemic Functional Linguistics (SFL)

Our qualitative text analysis of the documents is based on theories and methods
of linguistics, narratology, and literary critique. Preparing for the analysis, the
team discussed different theories and approaches to the empirical data, and we
agreed on an eclectic and pragmatic approach using a combination of methods.
The three papers that are the basis of this thesis varies as to which method
predominates, but a combination of analytical tools was used for each of them.

A main source of inspiration has been systemic function linguistics (SFL),
the linguistic theory elaborated by the British-Australian linguist Michael
Halliday and others, among them Christian Matthiessen (Halliday and
Matthiessen, 2014). According to Halliday, language is a representation of
human experience. Language works as a representation of reality and as a tool for
making communication effective even when our experiences of reality are
different (Maagerø E, 2005). Halliday and Matthiessen suggest two ‘basic
functions of language’ – firstly, making sense of our experiences by construing
and representing reality the way we conceive it (the ideational metafunction),
and, secondly, acting out our social relationships in which we appraise, inform,
question, order, and offer goods and information (the interpersonal
metafunction). Because these two functions act together in free combinations,
there is a need for a third component of grammar – the *textual metafunction* – to organise the text/speech and to construct the texts into a discourse, creating flow and making coherence. The term “metafunction” points to these elements as intrinsic functions for the analysis of language itself, not to the external purpose or intentional way of using language. The *ideational metafunction*, then, mirrors the speaker’s/writer’s conception and ideas of the world and is thus the reflecting and representing language. The *interpersonal metafunction* is the “staging” of social relationships in text; it is ‘language as action’ (Halliday and Matthiessen, 2014: 30). Finally, the *textual metafunction* is the ordering element of language, displaying whether and how things are connected to and associated with one another. All three metafunctions are present in one and the same text and are separated for analytical purpose only.

Grammar is not the neutral, technical elements of language, but the organising principle that makes meaning through a system of interrelated choices (Halliday and Matthiessen, 2014). The basic unit of analysis is the clause, in which the very core is the *process* (events and “goings-on”) and the *participants* (human beings, phenomena, things, concretes, and abstracts) that are involved in the process or are dependent on the process (ibid, page 213). In addition, there might be *circumstances* (time, place, mode) associated with the processes. According to Halliday, all human experiences can be represented by a manageable number of six process types.

The participants associated with the six different process types are separated into those who carry out the process and those who are the objects of the process (Table 1).
Table 1. Processes and the participants associated with them. Modified after M. Halliday & Matthiessen (Halliday and Matthiessen, 2014)

<table>
<thead>
<tr>
<th>Process type (examples of verbs)</th>
<th>Participant(s)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subject</strong></td>
<td><strong>Object</strong></td>
<td></td>
</tr>
<tr>
<td>Material (doing, happening)</td>
<td><strong>Actor</strong> (the one acting)</td>
<td>Goal, object, recipient, or client</td>
</tr>
<tr>
<td>Relational (having, being)</td>
<td><strong>Carrier</strong> (the one <em>having or being</em> something)</td>
<td><strong>Attribute</strong> (a quality or characteristic)</td>
</tr>
<tr>
<td></td>
<td><strong>Identified</strong> (the one <em>being</em> identified as something)</td>
<td><strong>Identifier</strong> (the unit that identifies somebody)</td>
</tr>
<tr>
<td>Mental (seeing, feeling, thinking)</td>
<td><strong>Senser</strong> (the one who feels, etc.)</td>
<td><strong>Phenomenon</strong> (the object that is seen, felt, etc.)</td>
</tr>
<tr>
<td>Verbal (saying)</td>
<td><strong>Sayer</strong> (the one who says, speaks, etc.)</td>
<td><strong>Receiver</strong> (the addressee)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Verbiage</strong> (the content of an utterance)</td>
</tr>
<tr>
<td>Behavioural (behaving)</td>
<td><strong>Behaver</strong> (the one who behaves)</td>
<td>–</td>
</tr>
<tr>
<td>Existential (existing, being)</td>
<td><strong>Existent</strong> (the one/thing that exists or <em>is</em>)</td>
<td>–</td>
</tr>
</tbody>
</table>


The grammatical system that realises the relationship between the processes and the participants (see below) is termed the transitivity system. This system is the grammatical and lexical (word-level) resources in the clause that embody human experiences in the form of process types, including happening, doing, sensing, saying, being, or having. The processes are qualitatively different as to their energy, that is, as to whether they bring about change in the physical world as construed by the text or if they stay in/maintain pre-existing realities or unfold within the world of consciousness, physiology, or psychology.

4.3.2 Narratology

In the narratological analysis of the texts, we used theories of literary critique. It is notable – according to what was previously said about the constructionist approach – that our analysis is first and foremost a piece of work dealing with the text, not with the reality behind the text.

Narrative analysis as a method investigates structures and techniques of telling, the sequences and consistency of the events and facts, and the interpretations provided by the narrator. The event, the ‘something happened’, which Labov and Waletsky call the complication of the story (Labov and Waletzky, 1967) and van Dijk (van Dijk, 1980) calls the worth telling, is a key concept. These refer to essential events having an impact on individuals, changing stable situations and conditions or life trajectories. Van Dijk’s concepts might apply to many stories of health and illness, and there are events (in this case a disease) that break the established norms (e.g. of being independent and self-supported) and routines (e.g. daily doings), threaten the basic values (e.g. being healthy), and disturb the balance (e.g. abilities and mastering), plans, and goals (e.g. relations, work, education) of the story’s protagonist (the patient, the claimant).

Even though the ideal starting point of the documentary text is the true event, as perceived by the narrator (Aaslestad, 2009), this does not contradict the notion that every narrative is a version of some reality and constructed for some purpose (Smith, 1980).

In fictional literary theory, narratologists usually distinguish between the historic author (the physical person with a formal name) and the narrator/writer...
(the telling voice in the text) (Booth, 1983; Genette, 1988). These terms are applicable and useful also to documents because the stances and views of the historic author (in our case the GP) might deviate from those of the narrator (the voice in the medical certificate) (Engebretsen, 2007). The historic author might have participated in the events that in fact took place, on the historic level, but the narrator belongs to the present. On this level, the narrator is ‘the one and only almighty actor’ (Engebretsen, 2007: 33). This is so even though the narrator has been delegated the power to “see” (deciding the level of knowledge) by the real author (Genette, 1988).

The author ‘is never neutral to all values’, Booth claims, and ‘even the most nearly neutral comment will reveal some sort of commitment’ (Booth, 1983: 71,76). The abstract character of this “norm carrier” – the implicit author – of the text has its corresponding abstraction in the implied reader or the possible reader, as Genette calls it. While the implied author is the reader’s image of the real author, Genette says, the possible reader is the image of the reader in the head of the real author.

The narrator’s voice might represent different perspectives, and it might be clearly present as the first person narrator (the ‘I’ of the text) who has no direct access to the minds of others, or as an all-knowing, invisible narrator, standing outside of the events, sometimes reporting the inner life of the protagonists.

4.3.3 Appraisal and rhetoric

Analysis of evaluative language (appraisal) is concerned with interpersonal and rhetorical aspects of text or speech, the linguistic means by which the writer (interchangeably here called the “textual voice”) addresses the reader. Martin and White’s elaboration of evaluative language is based on the linguistic concepts of systemic functional linguistics (see chapter 5.2.1) (Martin and White, 2005). According to these authors, evaluative language is the linguistic means by which the text

1. reveals the narrator’s feelings, attitudes, and values,
2. construes the narrator’s status or authority,
3. functions rhetorically to construct relations of alignment with potential readers, and
4. more or less directly activates readers/listeners to supply their own evaluations (Martin and White, 2005).

An important part of the narrator’s/writer’s construction of authority is how epistemic modality (the degree of certainty of knowledge) is presented and how the writer commits to what he/she is saying by the use of modality, vague language, etc. Categories of attitudes are shown in Table 2.

Table 2. Linguistic resources of appraisal (based on Martin & White, 2005)

<table>
<thead>
<tr>
<th>ATTITUDE</th>
<th>Affect (feelings)</th>
<th>Registering negative or positive feelings</th>
</tr>
</thead>
</table>
| Judgement (ethics) | **Social esteem.** Positive (admire) and negative (criticise)  
Normality: how special someone is  
Capacity: how capable they are  
Tenacity: how resolute/persistent they are
|                | **Social sanction.** Positive (praise) and negative (condemn)  
Veracity: how truthful someone is  
Propriety: how ethical someone is
| Appreciation (aesthetics) | The value we attribute to things and phenomena |
The elementary functions of interpersonal language, according to Michael Halliday, are giving or demanding information or goods and services; thus, they are speech acts anticipating responses from the reader who may accept or reject, acknowledge, disagree with, or ignore them (Halliday and Matthiessen, 2014). According to the Russian literary critic Michael Bakhtin, dialog is present in all texts; the text points backwards to what has been written before on the same objects, is influenced by it, and displays a stance toward it. At the same time, all texts point ahead, they anticipate – and are therefore influenced by – the responses of actual or potential readers (Bakhtin, 1981: 280). This corresponds to Genette’s view that an author can address only a “possible” reader (Genette, 1988: 149).

Martin and White have further elaborated upon the concepts of Bakhtin’s dialogism, saying that no texts are un-dialogical – because they always communicate to someone – but are more or less open to alternative voices and are more or less dialogical. In general, texts are different as to their dialogic style – they can be dialogically expansive in that they acknowledge and are open to alternative voices and value positions, or dialogically contractive in that they curb, silence, or deny alternative voices and their value positions (Martin and White, 2005).

In the dialogical project, the narrator displays his/her stances, feelings, preferences, and norms, positions him/herself toward their reader, construes ‘particular authorial identities and personae’, and establishes relations and alignments with the reader (Martin and White, 2005).

5 METHODS

5.1 Collection of material
This chapter describes the selection criteria and the material used. We wanted to achieve a purposeful selection of medical certificates so that they would have the potential of answering our research questions (Malterud, 2011: 56, Maxwell 2005: 88), not to ensure that the sample was representative of the entirety of medical certificates (as it would have been in a quantitative study). Our
recruitment strategy was to obtain a sample with which we could achieve a depth of understanding of these texts, but at the same time ensure a variation of texts according to age, region, sex and diagnosis.

The medical certificates were selected from the central data base of The Directorate of Work and Welfare. Three regions were selected due to their different distribution of people receiving DB, including Telemark (12.4% of the population receiving DB), Sogn og Fjordane (7.5%), and Nordland (11.6%) (NAV, 2013). The Directorate’s statistical department picked the certificates in accordance with our selection criteria. They distributed the lists of patients to the regional NAV offices who forwarded them to the municipal (local) offices, and the sampling of certificates was performed by the local NAV offices.

In order to avoid extreme cases, the distribution of principal diagnoses should reflect the statistical variation of diagnoses among DB recipients on a national basis, including 1/3 muscular-skeletal diseases, 1/3 psychiatric diseases, and 1/3 for all other diagnoses. To ensure an appropriate gender variation, we wanted at least 1/3 of the certificates to be written on one of the sexes. The diagnoses were electronically adapted from the ICD-10 code system used in the central database to the ICPC-2 code system of diagnosis (International Classification of Primary Care) used in the original certificates.

Due to a small number of documents obtained from these three regions, Vestfold (10% receiving DB) was added as the fourth region. The Vestfold material was collected by our direct enquiry to the regional NAV office. The office consecutively sent out letters of consent to patients whose cases were being closed until a sufficient number of certificates were obtained. This part of data material was not collected according to the criteria of sex and diagnosis.

5.2 Obtained material
All of the certificates were written between 2007 (after implementation of the NAV reform) and 2013, and all of the patients’ applications had been processed and all of the cases had been closed (decisions were made) at the time of sampling. We did not separate between granted and rejected applications because
information about the NAV’s final decisions was inconsistent. Characteristics of the GPs as certifiers (their age, sex, etc.) were not part of the study.

The documents were collected on the basis of the informed consent of the patients who had applied for DB. Due to the research design, which was qualitative textual analysis of information-rich documents, we estimated a need for no more 30–40 medical certificates. Expecting acceptance by at most one third of the selected population, 150 invitations were sent to patients who had applied for DB to request access to their medical certificates. One reminder was sent to all non-responders via the local NAV offices. Forty respondents gave their consent, of which seven were excluded either because their certificates were not written by a GP and/or because they were not medical certificates for work incapacity ordered by the NAV. Two certificates were about temporary benefits and were included because they were written on the same standard form requesting the same information from the GP. The local NAV offices removed identifying patient data before the documents were released to the researchers. The researchers had no direct or indirect contact with the respondents or with the local NAV offices, but corresponded regularly with the regional NAV offices during the collection process. The final composition of the 33 certificates is shown in Table 3.
Table 3. Characteristics of the medical certificates of disability (N = 33)

<table>
<thead>
<tr>
<th>Geographic region</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nordland</td>
<td>12</td>
</tr>
<tr>
<td>Sogn og Fjordane</td>
<td>3</td>
</tr>
<tr>
<td>Telemark</td>
<td>4</td>
</tr>
<tr>
<td>Vestfold</td>
<td>14</td>
</tr>
<tr>
<td>Male claimants</td>
<td>20</td>
</tr>
<tr>
<td>Female claimants</td>
<td>13</td>
</tr>
<tr>
<td>Age range of claimants</td>
<td>30–64 (average was the same as the median = 45)</td>
</tr>
<tr>
<td>Diagnosis (ICPC-2)</td>
<td>Main:</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>20</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>9</td>
</tr>
</tbody>
</table>
5.3 Ethical approval

The project was approved by the Norwegian Social Science Data Service (Personvernombudet). The Committee of Duty of Secrecy and Research (under the Ministry of Justice and the Police) permitted exemption from secrecy provided that the medical certificates had been de-identified/anonymised before release and that all respondents whom the certificates concerned had given their written consent. On the basis of this, the directorate of Work and Welfare (NAV) eventually approved the implementation of the project.

6 ANALYSIS

The use of analytical theories and methods in this project was the result of the authors’ collaboration. The team represented a wide scope of experiences in and knowledge of clinical and academic general practice, private and national insurance medicine, medical history, history of ideas, literature, linguistics, medical humanities, and qualitative research.

The multi-disciplinarity of the group was essential to how we approached the texts and for the choice of theories and analytical methods. Prior to the analysis, the group met several times – first to get an overall impression of the nature of the texts. We discussed our immediate impressions of the texts such as their narrative perspectives, their argumentative patterns, their use of metaphors, their rhetorical contents, what they emphasised and what they omitted, their perspective on the patient etc. The texts were read, re-read, and discussed, and analytical approaches were tried out during the first weeks until we agreed upon the analytical methods. The advantage of a group that represented an interdisciplinary attitude was a widening of the analytical perspective, and this helped to identify a broad range of data that otherwise would probably have been overlooked.

After the initial reading through of the material, our impression was that the texts were sparse, often fragmentary, elliptic (leaving out words), and with little discursive or narrative flow. It seemed that the apparent fragmentation of the doctors’ language – as we took it – was in part due to an important textual
context, the form. The GPs’ texts, therefore, needed to be analysed with respect to the form. We did not primarily consider the GPs’ information with respect to some golden standard or as to whether they were right or wrong, good or bad, true or false, or according to the form’s requirements, although the form’s relevance was commented upon. What we analysed were details that can hardly be regulated by law or guidelines, including the specific textual representation of humans and their conditions, what the writers emphasised, the way they construed and constructed how things hang together, the implicit and explicit emphasis on values, and the rhetorical means by which the writer addressed his/her reader to share his/her view of reality. In so far as we treated truth-related issues, this was related to the texts’ consistency in terms of information and their statements about causal relations.

Early in the reading, I noted that some texts contained information that had no obvious relevance to the patients’ medical condition, treatment or rehabilitation, or functionality or working capacity. Such data needed to be included in the study because they represented something unexpected. Some of them were personal statements – kinds of stated “facts” – about the patient, although some of them could not be termed facts because they were indirectly evaluating the patient as a person in addition to making statements about the future. These textual phenomena were included in the “evaluative language” that was treated in Paper 3.

Our empirical data were the linguistic elements that we identified, including grammatical devices, lexicals, clause units, and sentences. The elements were assigned to linguistic categories and then differentiated into categories of meaning related to the research questions that we aimed to answer.

In Paper 1, we investigated the participants and how the patient is represented as a person, his/her role in the process, and the role of other participants. The theoretical framework was the transitivity system as elaborated, among others, by Michael Halliday (Halliday and Matthiessen, 2014). In each sentence and clause, we identified all verbs and ascribed them to one of six processes and to the participants (humans, things, phenomena) that in some way were involved in the
processes. We investigated what kinds of participants the patients were represented as, what kinds of processes (material, mental processes, etc.) they were involved in, and who or what their co-participants were. We then categorised the findings according to the patients’ participant status and discussed them with respect to concepts of patient autonomy, involvement, and patient centeredness.

In Paper 2, the main approach was narratological. We investigated the structure and coherence of the disease and the disability narratives in which the narrators’ evaluations of events and causal relations were important issues (Labov and Waletzky, 1967). Furthermore, we explored the perspective of the narrator and how he/she positions him/herself toward the patient’s voice and other characters mentioned in the texts (Booth, 1983; Genette, 1988; Bakhtin, 2005). In the analysis, we also looked explicitly at the presence or absence of linguistic cohesion markers, grammatical devices showing important connections between statements, and whether these were causal or descriptive (Halliday and Hasan, 1976).

In Paper 3, we explored the evaluative elements and the different values, attitudes, and judgements that emerged in the certificates and the rhetorical and persuasive strategies that they used. The interpretation of the writers’ values and attitudes was made with reference to the framework of evaluative language systematised by Martin and White (Martin and White, 2005). We investigated linguistic elements of modality (must, should, etc.) and the grades of certainty and commitment with which the statements were advanced. Eventually, we identified various presentations as to whether statements were dialogically contractive (not opening to alternative voices on the issue) or dialogically expansive (opening to alternative voices).
7 RESULTS

7.1 Paper 1: Writing the patient down and out: the construal of the patient in medical certificates of disability

The objective of this paper was to investigate how GPs acting as certifiers represent the claimant as a person and participant in general and, in particular, as an actor. In this article, we analysed every clause in the whole text corpus, identified the verbs – the experiential metafunction – and ascribed them to one of the six processes (see chapter 4.3.1), that is, to what is going on in the clause. Our empirical data were the processes and the participants, picking a wide selection that included the whole variation of processes found in the text material. The processes (grammatically, the verbs) identify the patient and others as participants (the doer or the goal/object of other doers, as having or being something, etc.).

The most common types of process identified were relational processes, followed by material processes, mental processes, and verbal processes. Behavioural processes were not found, while existential processes were represented by one certificate.

The GPs commonly used depersonalisation and passive voice, resulting in the patients often being annihilated *qua* persons in the text and instead represented as passive carriers of symptoms. The GPs described symptoms as being detached from the persons having them and mostly without explaining what the symptoms meant to the patient’s functionality and life in general. The patients’ agency was low and described as failed, potential, conditional, or non-existing, and the patients were depicted as passive objects of the actions of impersonalised others. When represented as actors, their abilities and doings belonged to the past or were presently confined to dealing with the illness (taking part in therapy, going to treatment, taking medicines, etc.). In contrast to the patient, symptoms were foregrounded as independent, destructive, and efficient actors with the ability to control, delay, complicate, prevent, disturb, etc. In other words, the symptoms possessed an agency that exceeded the power of any actors in the texts, be they
the patients or the health workers. The patients’ personal experiences of illness were sometimes reported (‘the patient claims’, ‘the patient is convinced that…’), but these tended to be countered by the writer, especially when biomedical findings were absent. The writer’s voice, in such cases, was inclined to be doctor oriented rather than patient centred. The NAV policy of work-first – which presupposes the claimant’s involvement, patient centeredness, and adjustment of work rather than social benefits – was rarely mentioned in the medical certificates.

7.2 Paper 2: ‘Working is out of the question’: a qualitative text analysis of medical certificates of disability

The objective was to explore how GPs, as experts, represent and explain the patient’s disease/illness, functionality, and work capacity as narratives. The analysis followed a narratological approach.

- The form text

There are two main characteristics of the NAV’s standardised form text. Firstly, the form reflects the idea that there is both an immediate and predictable relation between disease and dysfunction/working capacity and that there is a medical treatment available that might improve, if not the patient’s health, then at least the patient’s ‘functional ability’ and ‘working capacity’. Secondly, in addition to a predominantly biomedical approach to illness, the form text does not issue the patient as a subject with his/her personal experience of illness, motivation, beliefs, and will of their own nor does it request information about relevant social contexts and how these might possibly influence the patient’s health, functionality, or capacity of work. The story being requested by the form text is the story of the disease, not the story of the sick person.

- The missing narrative: “nothing happens”.

The texts were characterised by synchronicity, and they were inclined to omit the qualities of narrative such as chronology, causal relations, and narratological
points, in other words, what had led the patient to become dysfunctional and work incapacitated. In the certificates, the depiction of disease was predominantly fragmentary, paying attention to symptoms. The lack of narrative elements blurred causality and variations of the illness course which was instead described textually as a continuous and non-contextualised state of being.

- **The doctor’s “chaos narrative”**.

Some texts reflected the problems arising when chronic disease is not valued by the NAV as a basis of DB, and they sometimes gave rise to a “doctor’s chaos narrative” in which the patient’s linguistic universe dominated (favouring symptom descriptions) leading to new or repeated examinations and tests.

- **Changing perspectives/conflation of voices and countering voices**.

The narrators positioned themselves through different perspectives (narrative voices): the all-knowing voice (the writer is the source and has insight into the patient’s ideas and thoughts), the indirect voice (the patient is the source), and the free indirect voice (the source of speech is unclear). The choice of perspective allowed the narrator to stand forward with authoritative statements, to create a distance from the patient’s claims, or to obscure who was saying or meaning what. It also allowed the narrator to either legitimise or distance her/himself from the patient’s linguistic zone (describing symptoms and problems) or to forward the doctor’s linguistic zone (explaining, contextualizing, and evaluating the symptoms and problems professionally).

In our dataset, some certifiers recommended DB even though they rejected the patient’s claims of having impaired functionality.

In two cases, quotation marks were used in connection with the patient’s free indirect speech, implying disbelief or irony.

- **Clarity and ambiguity**

The additive text type (sequences of finalised clauses and sentences without conjunctions between them) was frequently used. In many cases this obscured causal relations and temporality, allowing for a degree of inference. Hence, the
medical information was, in some cases, unclear or insufficient, sometimes ambiguous, and a few we took to be possibly misleading.

- Assessing functionality and working capacity on medical grounds.

Reports on the patients’ functionality were, with two exceptions, either completely absent or unspecified. Conclusions about working capacity were given without reasoning. The GPs acting as experts showed little insight into their patients’ working lives, but rather than express uncertainty and incompetence, they tended to make absolute and overly general statements about patients’ working capacity and failed to report thorough work ability assessments. The causes of the patient’s working incapacity were, in most of the texts, not obvious.

7.3 Paper 3. Acting by persuasion: values and rhetoric in medical certificates of work incapacity – a qualitative document analysis

Our objective was to explore the values, attitudes, and stances emerging in the texts as well as to explore the dialogical strategies used by the textual voice addressing the intended reader and how the narrator construed authority and positioned her/himself toward the reader and to other voices in the texts. On the basis of utterances selected by their description of attitudes (feelings, judgements, and/or appreciation) we identified five main themes regarding value. The empirical basis of these is found in appendix 3.

- Theme 1: The patients’ psychological health is reported to be deteriorated by the way they had been met by NAV officials (misbelief) or because the processing of their cases took a long time.

Statements about the patients’ feelings/emotions are attached only to their negative experiences with the NAV administration, not to the illness itself or to other kinds of problems related to their private life or to being a claimant.
• **Theme 2:** The patient “deserves” DB for possessing adequate values that are coherent with such as forwarded by the NAV and for having values accepted as universally positive, indicating that they are worthy claimants.

The values associated with deservedness were attached to attitudes of judgement that are typically forwarded by the NAV, including the patient’s willingness to contribute to and get involved in one’s own recovery, to participate in work training or education, and to minimise the economic burden of benefits to society (positive social sanction). Values attached to worthiness included the characteristics of sincerity, perseverance, tenacity, and sacrifice (positive social esteem).

• **Theme 3:** DB is assumed to make life better for patients represented with negative social esteem.

These patients are described as having low capability to improve their negative life patterns, for instance, because of drug abuse, dysfunctional personality traits, or social conditions that impede organising and planning enduring changes for themselves. They are represented as having low tenacity, low competence, and low capacity.

• **Theme 4:** Granting DB is argued for on the basis of the patient’s wish or as being a pragmatic solution.

The patient’s claims of being incapable of work or having low functionality are reported and serve as (the writer’s) arguments for DB. The argumentation for DB is also forwarded by referring to being “in the system” for many years (up to ten years) or trying different jobs, practices, etc., without having resumed employment. By using reported speech, the writer does not commit him/herself to the patient’s claims, but when the medical reason seems to be weak, he/she resorts to appealing for pragmatic and “realistic” solutions, that is, suggesting that the NAV should grant DB.

• **Theme 5:** Persuasive strategies toward the reader are used and are performed through bare statements, appeals, requests, and negotiations.
This concerns the way in which the writer addresses the reader by demanding actions. The dialogical style can be expansive (open to alternative voices) or contractive (rejecting alternative voices). While the former kinds of utterances reflect that the issue is debatable and is charged with uncertainty, the latter authorises the writer to have the right answer or solution, mainly through bare statements. In the texts we found both dialogical types. Dialogically contractive and dialogically expansive utterances can be found on a scale between bare statements on one side and utterances referring to the writer’s subjective and contingent view on the other (see Figure 4).

Figure 4: Increasing levels of dialogical expansion exemplified (the figure is presented only in the dissertation)

1) Bare statements, monological as they may seem, are dialogical (interpersonal) because they offer information to an imagined reader. However, this form does not acknowledge alternative voices and is dialogically contractive.

2) Using modalities and impersonal statements (must; it is recommended) gives the impression of expressing a general agreement. They conceal the writer’s
subjective stance, however, and are dialogically expansive, offering a type of information that can be negotiated with the reader.

3) By using explicit subjective statements (using pronouns or nouns), the writer takes full responsibility for and commits himself/herself as well as the specialist being referred to. They offer information about the writer’s stance (and the specialist’s) opening to negotiation with alternative voices: I (or the specialist) think such and such, but others might think differently.

The textual voices constructed authority primarily by aiming at sharing responsibility with the reader with a mixed rhetoric, forwarding not only medical “facts”, but also certain values and attitudes.

8 DISCUSSION OF METHODOLOGY

8.1 Remarks on the sampling of material

The criteria for the collection of certificates were chosen in accordance with a purposeful selection of documents to obtain an intensity sample that would be rich and varied, not extreme, deviant, or highly unusual (Patton, 2015).

We ended up with certificates with a larger number of muscular-skeletal diagnoses at the cost of psychiatric diagnoses (Table 3), and there might be various reasons for this. First, out of consideration for anonymity we could not influence from which local NAV offices the certificates were collected or whether they were from urban or rural communities. Second, claimants with a psychiatric diagnosis might be more reserved against allowing access to their medical certificates. One reminder was sent to the non-responders in three of the regions because one regional NAV office abstained due to lack of time and capacity. Third, the extended sample we added later using randomly consecutive selection contained a higher number of L-diagnosis (muscular-skeletal) than the others.

The distribution of diagnoses in the final sample compared to the selection criteria might theoretically be of importance if we assume that “psychiatric” certificate texts are essentially different from “somatic” ones and that variation or
nuances of information, due to few psychiatric diagnoses, might have been missed. However, of the six certificates with a psychiatric main diagnosis, only three were “pure” psychiatric (mono-diagnosed) and three were in combination with other diagnoses. In addition, somatic main diagnoses were combined with psychiatric additional diagnoses in nine cases, and many described psychological problems without reporting psychiatric diagnoses. Most certificates, accordingly, were of mixed types. We do not disregard, however, that a larger sample from some of the regions, or inclusion of more regions, might have brought more nuances to our analysis.

8.2 Internal validity
The validity of the results, as suggested by Joseph Maxwell, is related to the correctness of the descriptions, interpretations, explanations, and conclusions of the analysed data (Maxwell, 2005). In the following, I discuss factors that might have influenced the results and the conclusions drawn.

8.2.1 Reactivity
In this thesis, we are dealing with data sources (documents) that were produced independently of the research project and that were obtained as ready-made data material. A strength of using documents as data material is that they are stable data produced without the influence of the researcher (Maxwell, 2005; Bowen, 2009; Corbin and Strauss, 2008; Silverman, 2014). Because they are pre-made data, we do not ask for respondent feedback (from their producers) to “get it right” as is done with respondents in interviews (Maxwell, 2005). Only at the stage of reading, interpretation, and analysis does the researcher influence how to read and understand them. It is therefore necessary to discuss factors that might have had an impact on the researcher’s choices.

8.2.2 Reflexivity
I started to define my research project and to study the documents with lenses that were coloured by my experiences as a GP and as a previous medical adviser in the NAV. One of my concerns as a GP was the writing of medical certificates and my contact with the NAV on behalf of patients that I had known for years
and whose life situations were familiar to me. In contrast, as an adviser for the NAV, I was not supposed to meet all the claimants personally, but usually just relate to their case documents. Frequently, the medical certificates, a central document in every case, left many questions unanswered or were too vague, and making important decisions on the basis of them did not always seem right or fair. Having face-to-face meetings with the claimants to collect more information seemed therefore to be reasonable. I became aware of two things – the certificate’s great importance for the processing of DB (which surprised me) and the great variation of their qualities (that is, as expert documents providing a good basis for decision-making by the NAV). They ranged from complete and dedicated writings to papers that were almost useless as the basis for a decision.

When “thin” certificates led to delays or rejections, the claimants tended to criticise the NAV, not their GP whom they usually seemed to have great confidence in (GPs always seemed to support their patients’ claims, either directly or indirectly). I therefore sometimes advised the NAV officials to request more information or called for meetings with the GP and the claimant. I was then surprised at how much important and decisive medical information could be added to make the certificates complete. Sometimes it was new information that was not given in their primary medical certificates, and which might influence the processing of DB. My experience as a reader of GPs’ certificates was that only rarely did they seem fully adequate, correct, and sufficient. This was my pre-understanding of the material that we set out to investigate and which, I believe, has affected my analysis and sharpened my critical reading skills. I am aware that there might be alternative readerships with other nuances of interpretations.

Prior to the study, I was imbued with the idea that GPs’ medical certificates in general had a large potential for improvement. As an internal medical adviser for the NAV, I had learned that these certificates are not only very important documents in the processing of DB, but also that the certifiers, the GPs, did not always seem to realise how important they really are. I had the perception that this might explain some of the large variation of the quality of their certificates.
Negating my experiences and critical gaze and “resetting” myself, however, was not a realistic option.

8.2.3 Credibility

There are two factors that I consider to be important in this study for countering or balancing biased selections of data. Firstly, my co-authors, by suggesting alternatives and by supporting perspectives beyond the “standards” of medical certificates, opened my eyes to the different ways of thinking about texts. Two of my co-authors, Eivind Engebretsen and Eva Maagerø, had no first-hand experience with either reading or writing medical certificates. Their “naïve” reading and discoveries of textual details inspired me to approach the texts with new perspectives and with alternative interpretations. Secondly, the best antidote to avoid picking “confirming data” was to select data in a way that did not exclude any element that might have even the slightest relevance to the topic. The method as such does not secure the validity of the data, but it is helpful in realising all of the evidence that the empirical data represent (Maxwell, 2005). The analytical tools were also operational, and when looking for processes and participants for Paper 1 we used a grammatical system (SFL) that was a guide to identifying all the relevant data. Eva Maagerø, professor of linguistics and literature, looked over the data selection with respect to the theoretical frame of SFL and suggested corrections and new interpretations.

In the narratological approach used in Paper 2, we sought linguistic devices and meaning content that would allow us to draw conclusions about coherence and reasoning in the certificates. This was probably the part of the project that was most prone to the “subjectivism” of the analysers, as coherence – the hanging-togetherness of a text – is not only the responsibility of the writer; it also depends on the reader’s willingness and ability to create meaningful relations between facts, events, and evaluations (van Dijk, 1980). The method was exhaustively selecting whole sequences of texts containing sentences and reasoning and analysing them according to narratological principles as explained in chapter 4.3.2.
Value is a central concept in Paper 3, and this might be vaguely and implicitly present in texts and speeches. To obtain the relevant data related to values, we needed a framework that would sort out a variety of linguistic devices that could be considered expressions of values and as promoting values. The multitude of possible interpretations of what values are and what was “rhetorical” in the sense of serving as persuasion needed to be structured and delimited. For this purpose, we leaned on a linguistic framework of appraisal (Martin and White, 2005). However, the variety and subtlety of rhetorical language encompasses far more than linguistic, single-worded elements of appraisal; there are also semantics of utterances that can be associated with appraisal within different cultural, professional, and social contexts. These have been subject to our interpretations based on knowledge about the context. It would not be realistic to assert that such interpretations are not coloured by my personal experiences as a certifying GP and as a medical adviser for the NAV or by research-based knowledge of GPs’ certifying practices, as already mentioned in this chapter.

In this project, we used text analysis as the only method, though with different analytical techniques. This can possibly be seen as a weakness of the study’s methodology. Additional methods such as triangulation are not a guarantee of validity, but might reduce the risk of ‘chance association and systematic biases by using a single method’ (Maxwell, 2005: 112). In our project, we found that the texts were rich enough to sustain three different text analytical outlines, and removing one of them might not have justified the variation and character of these texts. The co-operation of researchers with different backgrounds (medicine and the humanities) and the use of acknowledged theoretical frameworks in the analysis provided us with data relevant to answering our research questions.

The analysis and interpretation of data are in some way or another influenced by the researcher’s choices, which is why the results might not necessarily be accurately repeated by other researchers. This is to say that repeatability might not be an adequate measure of reliability (Malterud, 2011).
While we cannot – and should not – claim that our results are generalisable to GPs’ medical certificates beyond our material, we have reason to believe that they are transferable to the field of certifying GPs. The strategic selection increases the probability that the findings can be recognised and seen as valid among GPs who actually act as experts.

8.3 Translation of the texts.
It was unavoidable that nuances in the meaning of a few linguistic elements would be lost in translation and that new meanings and nuances might be added. This was particularly the case in the translation of modalities (burde, skulle/ought, should) and in translating some idioms and a few elements with metaphorical or value-laden meaning (for instance, ‘she has been cheating a little on her diet’ was translated from ‘hun har skeiet litt ut i forhold til dietten’). We discussed the translation of meaning in such cases and agreed that the content was more important than a verbatim translation. Nearly all clauses and sentences were translated as closely as possible to the original text and were not found to be problematic.

8.4 Using medical certificates as primary data
By studying the discourse of medical certificates, we can get access to the details of the reality they represent and that forms the basis of decisions. As previously shown, many empirical studies have been performed on physicians’ experiences with and attitudes toward certifying work incapacity. Direct studies of medical certificates written by GPs seemed to be a natural continuation of these studies. The certificate is the result of their practices as certifiers, but until this study these certificates have not been investigated. The “show, don’t tell” strategy of exploring how GPs in a selected material of medical certificates practice their role as certifiers and act it out in their writings is something we consider to be a strength of this study.

We have not aimed at comparing the medical certificates to some “objective standard” of how to write them. The role of document analysis is rather to investigate how people and phenomena – in our case patients, disease, and work
capacity – are being represented in text. Important ‘truth-related issues’ in documents are relevant, though, and particular biases might push constructions of reality in particular directions, and certain aspects of reality might be interpreted differently (Silverman, 2014: 277). These are issues that we have paid attention to throughout our readings, our analysis, and our discussion of the results.

8.5 Ethical considerations
The relatively small number of participants implied a risk of being recognised in certain contexts, and thus the original material was treated with caution. Following every reading by the group, the certificates were retrieved by the responsible researcher (GAA), the copies were destroyed, and the material was kept in locked storage. We avoided any geographical information, and all excerpts used in the articles were decontextualised. The excerpts were short and were not identifying of individuals.

9 DISCUSSION OF RESULTS

‘Through the resulting abuse of words, doctors may often constrain and limit the patients’ stories, consigning many of them to stories of failure, and reducing their capacity to celebrate, or even recognise, achievements’ (Iona Heath, 2001)

The results presented in this thesis are, firstly, discussed in relation to concepts of patient (or user) involvement, patient autonomy, and integrity. Furthermore, I discuss the complexity of gatekeeping and the role of the GP as an expert within a field that is in part not accessible to objective descriptions. On the basis of Paper 3, I finally discuss values and rhetorical strategies.

The gatekeeper term in cases of DB does not formally apply to GPs and can be somewhat misleading. The certifying physician is part of the process of
welfare decisions, but has no formal decisive power. However, in Norway the gatekeepers in charge, the NAV officials hold the medical certificate to be the most important informational basis of their decisions (Lima and Nicolaisen, 2016; Gjersøe, 2017). Despite this, eligibility criteria are vague and negotiable in every individual case and, accordingly, the room for discretion is wide.

9.1 A language for the claimant

While patient involvement, autonomy, integrity, and responsibility are concepts found in modern legislation regarding patients’ rights and health personnel’s obligations, in the National Insurance Act (Folketrygdloven), and in the ethical rules of the Norwegian Medical Association, the medical discourse has never been deliberately subjected to changes considering how patients are represented in text.

A characteristic feature of the certificate texts is the patient represented as a victim to symptoms, a depersonalised and pacified individual who is dependent on the actions and decisions of others. However, within the context of the medical certificates, heroic connotations are not unusual. A usual metaphor of action is the patient who ‘fights’ to stay in work (the working place suggested to be a “battlefield”), but who – due to health problems – does not succeed in returning to work. This narrative is strongly related to the worthiness of the patient applying for DB; the claimant’s preference is to stay in work, but they are prevented from doing so by forces that are beyond their control. The narrative is crucial to undermining suspicions of malingering, laziness, and fraud. It is reasonable to believe that writing the patient down as an acting person and out of the labour market’s possibilities – as shown in our material – is a textual project that, at least in part, is deliberately or strategically chosen to help the patient (Gulbrandsen et al., 2004). The idiosyncratic language in the certificates seems to reflect many aspects of the expert role, including a genuine wish to help the patient get DB (advocacy), lack of time, avoiding conflict (convenience) (Gerner and Alexanderson, 2009; Arreløv et al., 2007; Hussey et al., 2003; Lofgren et al., 2007; Overland et al., 2008), and the certifiers’ problems with functionality/work
ability assessments and/or writing skills (incompetence) (Steinhaug og Hem, 2006).

Our analysis illustrates a particular feature of this genre that has also been pointed to by others, namely, a tendency in the documents to reduce patients to a mere function of their illnesses, despite whatever other activities the claimants commonly indulge in (Prior, 2011).

Characteristic of this discourse is also the depersonalisation, or annihilation, of the patient, using ‘symptoms’ for ‘person’, and corresponding to this the impersonalised and hidden role of the medical writer. This is in accordance with medical genres as we know them from Hippocratic bedside reports to the modern hospital records and case reports, in which the privileging (‘objective’) perspective of medicine rather than that of the patient’s subjectivity predominates in the texts (Taavitsainen and Pahta, 2000; Berg, 1996; Montgomery, 1991; Hurwitz, 2006).

It is, however, not obvious why the family physician, with his/her in-depth knowledge of the patient and their context, would resort to a language that depersonalises the patient and makes the writing physician invisible, in particular if helping the individual patient is a concern. However, previous research and that which is presented here indicate that the certifier most likely needs to balance the language in consideration of the patient and the decision-maker. On one hand, non-substantial (read: non-medical) statements such as “As her GP, I have known Mrs --- for twenty years and there is no reason to doubt her claims that she is one hundred percent work disabled now” might put the certifier’s legitimacy and objectivity at stake. The patient might perceive it as sympathy, increasing their confidence in the GP, and reducing tension in their relationship. If the certifier, on the other hand, borrows typical genre terms from traditional medical language to mark a professional distance or to make it seem objective, it may increase his/her reliability and authority with the decision-maker, the reader. The certifier keeping in mind the two addressees – the NAV official and the patient – is a crucial point illustrating how opposing considerations crisscross in the texts and contribute to their idiosyncratic style.
Focus group interviews with GPs frequently refer to the impact of the patient on their certifying practices, the medicalisation of life problems, and patients’ liberal attitudes toward sick leave, as being problematic to them as certifiers. Nevertheless, open disagreement or conflict is hard to discern in the texts they produce.

Rather, the “language of work incapacity” as shown in this thesis corresponds to a paternalistic undertaking that implicitly regards itself as a speaker for the patient, supposedly in his/her interest, but at the cost of the patients’ personal responsibility and ability to speak for themselves. I will term this language textual paternalism because it might not necessarily reflect paternalism in GPs’ clinical practices. In their outlines of ideal-type doctor-patient relationship, Ezekiel Emanuel and Linda Emanuel define the classical paternalistic doctor as ’the patient’s guardian, articulating and implementing what is best for the patient’ (Emanuel and Emanuel, 1992). The second ideal-type is the informative (or the consumer) model in which the doctor acts as a provider of technical facts but leaves decision-making entirely to the patient. In the third ideal-type, the interpretive model, the doctor is a value-oriented counsellor who, together with the patient, aims at helping the patient to recognise his/her general values as the basis of decision-making. Finally, in the deliberative model, the doctor acts as a friend or teacher and only health-related values are issued. The patient is empowered to increased autonomy and self-development through dialog and considerations of alternative health-related values, and this is the authors’ preferred model (Emanuel and Emanuel, 1992). The ideal-types are related to the doctor’s role, to degrees of patient autonomy, and to collaboration in clinical situations. It can be well argued that they might also apply to issuing of sick-leave and medical certificates because the social benefits connected to them are closely attached to values and have social implications. Our analysis indicates that there are features of the first ideal-type, classical paternalism, in the language form of the medical certificates; the certifier assumes responsibility for the patient, acts as the patient’s guardian, articulates what is best, and concludes – directly or indirectly – that DB should be granted. We cannot draw conclusions
about the doctor-patient relationship “behind” the certificates, but many of the
certificates apparently use paternalistic language to authorise or justify the
patient’s wish or demand, more so by the linguistic form than by medical
evidence. There are strong indications that certifying of work disability is
frequently issued on the basis of patients’ demands even when lacking relevant
medical evidence (Claussen, 1999; Mannelqvist et al., 2010; Lima and
Nicolaisen, 2016).

Acting in accordance with the patient’s demands or wishes, as in such cases, I
argue, fits neither into an ideal model of paternalism as outlined by the
Emanuel’s, nor to a true consumer-model, but rather is likened to a crippled form
of “autonomy” and might be a sign of disclaim of professional responsibility.
The result of this certifying practice, I believe, might be reflected in the
document texts as ambiguous information, incoherent reasoning, and deficient
information about functioning and work ability. This may be one way of
“adjusting” the language as part of an alternative strategy to strengthen the
patient’s cause (Getz et al., 1994; Gulbrandsen et al., 2004). In our material, we
do not have evidence of adjusted or manipulative language because this relates to
truthfulness to some external reality that is outside the scope of this thesis. The
reference to the Council in the introduction of this thesis, however, shows that
the unambiguous construction of the “deprived” patient is not necessarily in the
interest of the patient, and might even be detrimental. Studies support that
patients value their personal integrity and power as even more important when
afflicted by chronic disease and that in research interviews they might provide
useful information that is often ignored in the medical texts (Juuso et al., 2012;
Paulson et al., 2002; Råheim and Håland, 2006).
A repeated and problematic issue of sick leave as reported by GPs is dealing with patients with health complaints or illnesses without any evidence of pathology. Søren Brage found, in a focus group study, that the GPs usually meant that assessments of physical functionality were ‘straightforward’, aside from cases in which underlying pathology was not detectable (Brage, 2008). There is a discrepancy, Brage suggests, between the GPs’ conceptualization of patients’ functionality in terms of a complex, biopsychosocial model on one hand, and implementing it in clinical practice and in certifying that is in accordance with insurance legislation on the other.

Even though a clear-cut division between so-called functional illnesses and somatically explained diseases is no longer valid within modern medicine, the NAV is assumed to have contributed to maintaining such a division (Brage, 2002). Among other things, the NAV form, “Medical certificate of work incapacity”, implemented in 1999 and still in use, implicitly presupposes a simple biomedical disease model (Solli et al., 2005; Solli, 2007). Even so, the diagnostic categories rated as the least verifiable (symptom-based diagnosis) are the most common in DB awards (Overland et al., 2008). Accordingly, there is room for negotiating illness as a cause of work disability with the decision-
makers. This does not necessarily make certifying work easier to perform. In Paper 2, we commented on the NAV form. The form reflects the idea that there is a clear illness story, an immediate and predictable relation between disease and dysfunction/working capacity, and a medical treatment available that may improve, not necessarily the patient’s health, but their ‘functional ability’ and ‘working capacity’. This might indicate the belief that medical treatment might act as a shortcut to returning to work, which is rarely the case. Considering that about two thirds of those receiving DB have diagnoses of minor psychiatric conditions and symptom-based illnesses, I argue that such a logical chain of reasoning as suggested by the form belongs to a theoretical world. It might mislead the NAV into demanding that the claimant should go through specific treatment without taking into account the claimant’s individual context.

The NAV form, furthermore, emphasises what the claimants cannot do, rather than their capacities. The NAV form used by GPs generates a passive language, directs a certain biomedical approach, favours reductionism, and does not ask for the patient’s own perspective on his or her disease or symptoms. The form seems to encourage answers that are sometimes too simple and that might challenge the physician’s holistic way of thinking, their integrity, and their autonomy of discretion. In this respect, the form is not only the director of the certificate, but also, in some respect, a co-author. The rhetoric of a medical certificate, then, tends to be oriented toward avoiding descriptions of the patient’s factual capacities, integrity, and strength because such characteristics contradict the image of a work-disabled person.

The medical certificate is a particular genre of medical text, hovering on the border of law and medicine. For the certifier to reach a conclusion about the claimant’s work capacity, the reader needs to see beyond “the medical” and must construe coherence between illness events, medical findings, and professional evaluations of work ability. In many of the certificates in our sample, coherence was difficult to find, most frequently due to deficient descriptions of the patient’s functionality and reporting of their work situation. Conclusions about the claimant’s working capacity were frequently put forward either vaguely or with
strong certainty. This finding is largely in accordance with other research results (Lima and Nicolaisen, 2016; Steihaug og Hem, 2006; Overland et al., 2008; Engblom et al., 2011; Mannelqvist et al., 2010).

Overland et al. have suggested that low verifiability of diagnostic categories related to work ability assessment might explain why GPs find the certifying task to be problematic. GPs repeatedly report, in many studies, that subjective health complaints are hard to assess and to relate to the patient’s (dis)abilities. However, we found in our text sample a tendency that assessments of work ability were deficient or absent in symptom-based as well as in objectively verified diagnoses. This might indicate that work ability assessments can be genuinely problematic regardless of diagnosis. However, physicians, in their work assessments, might also favour diagnostic categories that serve to verify the patient’s illness because they might be more easily approved by the NAV.

The hybrid status of the GP means acting at the intersection of expert professionalism on the one hand and medical practice in the best interest of the patient on the other. In our text material, deficient information, subtle use of language, unclear sources of speech, and textual ambiguities reflect that some GPs show little understanding of the document’s legal character. This “insurance incompetence” is in accordance with other research results (Mannelqvist et al., 2010; Engblom et al., 2011; Lima and Nicolaisen, 2016) and is most probably related to lack of occupational insight and difficulties in assessing work capacity, as reported by GPs in some studies (Mandal and Dyrstad, 2017; Money et al., 2010; Gerner and Alexanderson, 2009). We found that GPs’ “strategic writing” seems to entail a variety of chosen linguistic techniques, some of which are subtle, such as using quotation marks, vague language, and reported speech. This might in part be due to claimant advocacy when substantial pathological-medical grounds are absent, dubious, or weak. However, GPs might also use it to signal disagreement with their patients toward the addressee, the reader. In such cases, the writer might avoid being blamed by the claimant by considering him/her as a “super-addressee” to whom the text is not directed, but who is a legitimate reader of it (Bakhtin, 2005; Engebretsen, 2007). Vague and ambiguous language as a
possible intended strategy might mirror physicians’ real problems with how to assess, verify, and report patients’ functioning and working ability, as well as with how to avoid conflict or to maintain a good relationship with the patient. These issues are broadly reported on in other studies (Gulbrandsen et al., 2004; Carlsen and Norheim, 2005; Foley et al., 2012).

Symptoms and general conditions for which there is no medical explanation or effective treatment sometimes result in what we have called the text’s chaos narrative. This is the story without an end, reflecting the doctor’s impotence when stuck with the patient who cannot get NAV’s acceptance as work disabled. In addition, I argue that there are other signs of textual chaos that mirror the certifier’s real conflicts, such as disconnected listing of symptoms, ambiguities, conflation of voices, missing time aspects, and absence of causal relations that might indicate a narrative point as to why exactly the patient’s health condition impedes their ability to work. In this respect, the ‘untidiness’ of the texts might be a symptom of the doctor’s incompetence in unifying the two roles of physician and expert, or of the impossibility of doing so. Some certifiers might partly adopt the distancing language of medicine in trying to represent the illness as existing independently of the patient’s subjectivity as well as of the doctor’s, while others might draw on the patient’s experiences and their own discretionary judgements. In general, the enormous variation of language and textual meaning and the many possible layers of textual construction imply that a legal rule about certificates can only point out the general criteria of expert certificates, not \textit{how} to write them.
9.3 Values and worthiness

‘Values are often tricky to pin down because they are such a pervasive part of things we take for granted’
(Kelly et al., 2015)

One of the most obvious and coherent argumentation chains in the certificates (Paper 3) was the forwarding of certain values and stances corroborating recommendations of granting DB. The certifiers’ attitudes and the values they advanced on behalf of the patients, as well as the values they implicitly anticipated to be held by the readers, were intertwined and used as part of the argumentation. All the certifiers showed, implicitly or explicitly, a positive stance toward DB even though some of them displayed disagreement with the patient’s own (reported) evaluation of his/her health condition. The values they promote are partly those that are strongly relevant to – but not demanded by – the politics of the National Insurance scheme, such as the client’s cooperative abilities, motivation, and willingness to resume work.

Other values found in our material are universally accepted, such as the patients’ positive personal character (alluding to deservedness) or the possibility of having a better life with DB (calling for the reader’s compassion). They are, however, irrelevant to the NAV, which ranks disease as the key value, followed by real reduction in functionality and work capacity. However, argumentation based on factual medical information and how it affects the patient’s functionality is not emphasised in the texts we have studied, mainly because descriptions of functionality are absent in most certificates.

In our material, we found that GPs as experts generally act as the patient’s advocate, and they sometimes seemed to do so even while disagreeing with the patient’s health claims. An interview-based study found that GPs as certifiers sometimes adapt to governmental restrictions on the criteria for DB by taking a
distancing position as the disinterested bureaucrat, while others intensified their role as an advocate (Getz et al., 1994).

It is questionable whether the GPs are conscious that they are guided by certain values in their assessments and whether they are aware of the implications of these values. Terum and Nergård found a significant correlation between the GPs’ attitudes toward living on DB and their personal norms, and GPs expressing strong scepticism toward living on DB made more restrictive assessments of the individual applicant’s eligibility criteria. Consequently, the authors questioned the dichotomisation of advocates and bureaucrats, finding this to be too simple. They discussed the term “professional discretion” and regarded it as problematic. “Professional”, they argued, cannot be taken for granted when the physicians’ personal attitudes of morals and values have a large impact on their judgements. Terum and Nergård concluded that physicians rarely problematise that their personal norms and values influence their clinical practices. While the physicians are inclined to delimit and define medical science as a discipline, they do not set limits to the exertion of medicine as a clinical activity (Terum and Nergard, 1999).

Our study suggests that the certifying physicians’ values are constant and stable and with little variation between individual cases. Whereas all the thirty-three medical certificates, either explicitly or implicitly, argue in favour of granting the patient DB, they did so on various grounds, as shown in Paper 3. The textual findings are also in accordance with Claussen’s additional evaluation of the certificates written in 1991 and 1993, that none of them had ‘the outlook of a neutralist specialist statement, but (…) expressed the opinion of the GP very clearly’ (Claussen, 1999).

Neither of these studies, then, support the division of GPs as either “advocates” or neutral “consultants” as previously proposed by Getz and Westin (Getz et al., 1994). In our qualitative study, we found that all the certifiers acted as advocates, although some did so ambiguously. These discrepant interpretations might in part be explained by the different methods used – investigating texts to see what GPs actually write on the one hand, and conducting interviews to find what they claim
to do on the other. Documents as data – in contrast to interviews – are reliable, stable, and undisturbed by the researchers’ influence on the production of these data (though the interpretation of them is not), and this might have been of some importance to the different results.

In the selected text material, we found that advocacy predominates, but that the advocacy perspective is complex and probably difficult to deal with as text. The reason for this might be that the claim needs to be argued for on professional grounds (which might be difficult), and there are also indications of doubt, ambivalence, disagreement, and possible conflicts in the texts. Furthermore, we should not overlook that clear writing and reasoning about work incapacity might be difficult even in cases of illness that in fact can be medically explained.

Interviews regarding GPs’ attitudes find that “illness” is complex and that the patient’s impact on the GP is strong. In addition, “unfitness for work” might comprise wide grey areas of ill health and of social and personal and life problems, thus “working capacity” is poorly defined and disease might not even be on the list of decisive factors as considered by GPs, as reported in a Swedish study (Sturesson et al., 2013). This might in part explain why clear connections between disease, functionality, and work incapacity are missing in many certificates, giving way to an emphasis on values and rhetorical appeals.

It is not conspicuous that GPs’ personal attitudes and values influence their certificates. Being guided by values is not in itself irrational or problematic. It is not even problematic that these values might not be immediately discerned by the reader or when they are only inferred by him/her. It can be a problem, however, when the rhetoric replaces professional information that might justify important decisions, such as the allocation of social goods. With this being said, we are aware that descriptive texts also have a purpose, and even aiming at neutrality is in itself a value position with consequences (Corbin and Strauss, 2008).

9.4 Comments on the NAV form “Medical certificate of work incapacity”. The GPs’ texts can hardly be analysed without bringing up the NAV form as a textual context.
The most frequent criticism of the NAV form in use today is its assumption of a biomedical illness and its neglect of social, familial, and economic factors that are of significance to work-life and health (Aarseth et al., 2012; Solli, 2007; Solli and Barbosa da Silva, 2012). The socio-economic risk factors for work incapacity are well documented (Krokstad et al., 2002) but are not asked for in the form. Furthermore, Solli has argued in favour of a value-based, relativised concept of disease that includes a focus on the patient’s other abilities, motivations, plans, or resources (Solli, 2011; Solli et al., 2014). These factors are entirely omitted in the form. There is thus reason to believe that the narrow concept of work incapacity signalled by the form has a strong impact on GPs in their role as certifiers (Mik-Meyer and Obling, 2012; Gulbrandsen et al., 2007; Brage, 2008). Even though GPs might be conscious of non-medical factors’ importance to illness, this is difficult to implement in the certificates (Brage, 2008), and this might be a reason for the lack of reasoning and transparency in their medical certificates (de Boer et al., 2008).

In the following, I argue that, in some respects, the form can be said to be at odds with some legal and ethical considerations that are valid within the health and social services.

Firstly, the legal rules § 4 (Forskrift til krav om helsepersonells attester, 2008) state that the certifier must declare his/her possible ‘doubts or uncertainty about the facts, evaluations or conclusions’ in the certificate. The certifier’s reservations and uncertainties, however, are not asked for in the form. Rather, I argue, the form excludes uncertainties and the need for nuanced answers. An example of this is that the certifying physician’s evaluation of the patient’s working capacity is a polarising tick-off act (form section 5.3: yes/no) without room for explanation, specification, differentiation, or doubts (Solli, 2007). Thus, the conclusion about the patient’s work capacity ‘is made implicitly’ (Solli, 2007: 423-424). The argumentative shortcut, instead of a step-wise outline of reasoning, that the form sets up might explain why some certifiers jump to ‘hyper-conclusions’ about the patient’s functionality and work ability (Steihaug
either without providing reasonable and relevant data or without justifications or reasoning and, hence, without transparency.

Secondly, the legal rules presuppose that facts and evaluations have documenting attachments. However, the form does not ask for the sources on which facts, evaluations, and conclusions are built. This might contribute to the common finding in our analysis of the conflation of voices and the obscuring of sources.

Thirdly, there is a discrepancy concerning the perspective on the patient’s work capacity. The National Insurance Act directs attention to the claimant’s actual capacity ‘in spite of health problems’ (NAV, 2017a), while the form asks for limitations, what the patient ‘cannot do in the present work’ (sections 4 and 5.4a) (Aarseth et al., 2014). Arguing for limitations probably directs the GPs toward emphasising incapacities and hindrances for functionality and work, describing symptoms rather than persons. This supports our findings that, after reading the GPs’ documents, we often still do not understand why the patient is entirely unfit for work, and this might serve as an example of the form’s strong impact on the GPs’ text.

Fourthly, user democracy within the health and social services is regulated by law and is widely accepted and formally legitimate (Aasback et al., 2013), and it might well be argued that the form text is at odds with the view on user democracy within the social services (Haukelien et al., 2011). The 1999-form gives no direct access to the patient’s voice. It does not ask for his/her cognition of the illness, nor does it seek first-hand information about the way the patient sees it, and this might be important to the processing of the application. Leaving out the patient’s textual contribution, I argue, might be contrary to seeing him/her as a participating, committed, and responsible subject with their own experiences and aims.

My fifth and last comment is about section 10 in the form that allows the GP’s to reserve, on medical grounds, against the patient’s access to the medical certificate or to parts of the information. The GP is not requested to give any reasons as to why such reservation is made; accordingly, a reservation can be
made without reasoning or lawful warrants. As a main rule, a person has the right to access and view documents treating individual cases (Forvaltningsloven, 1967) and medical records (Helsepersonelloven, 1999). Access to medical certificates (that have some resemblance to patient records) can be denied ‘to prevent the risk of life or serious health damage to the patient or the user himself (…) or to persons that are close to the patient’ (ibid. Chapter 5-1). It is not obvious why a medical certificate of disability would contain potentially “health damaging” information that would be of importance to the NAV. Even though section 10, is, probably, practically inert today, its legitimacy in the form is questionable.

The sicknesses most frequently leading to DB are minor psychiatric disorders and ‘subjective illness without disease’ that rarely allow unambiguous statements about their causes and about their ‘prognosis, duration, treatment and rehabilitation’ or allow a precise ‘objective’ description of the patients’ functionality, as requested by the NAV form. It might therefore not be surprising that the rhetoric of work disability is “poly-linguistic”; the texts move into and out of the “neutral” or detached professional language and into and out of precise, subtle, ambiguous, assertive, appealing, and urging language. It is an idiosyncratic discourse, emerging at the meeting point of many different considerations, including the limitations of the co-text (the standard form), the problem of mere symptom-based illnesses as a cause of incapacity benefit, the complexity of “functionality”, the patient’s impact, the doctor-patient relation, and the doctor’s ethical attitudes as a gatekeeper.
10 WHAT ARE THE RESULTS RELEVANT TO?

‘Fidelity to patients, including strong advocacy on their behalf, is noble, but it should not cross the boundary of the disclosure of truthful clinical information to which an impartial reviewer is entitled’
(Beauchamp and Childress, 2013: 311)

10.1 The professional integrity problem

The exertion of accountable, professional judgement is essential to the integrity of the certifiers. The Code of Ethics for Doctors says that “a doctor shall not issue a medical certificate if he/she is in doubt as to his/her competence. If a doctor does not find objective grounds for issuing a certificate, a certificate shall not be issued” (Legeforeningen, 2015). In the NAV form of 1999, there are sections that might be challenging to the physician’s professional integrity.

The main “threat” to the physician’s integrity is, as shown in chapter 9.4, that the form ignores the physician’s possible reservations, uncertainties, doubts, and open reasoning, all elements that might make them accountable. The form instead is oriented toward getting clear answers, of which there are few within general practice. In addition, it has some formulations that might be misleading. For example, the form asks the GP to ‘describe how the functionality in general is reduced because of disease’. In medicine, describing is made on an empirical basis and the interpretation of the description is based on professional knowledge. Strictly speaking, the physician usually has no direct knowledge of the patient’s functionality so as to make a description of it because the patient’s daily functionality belongs to the private spheres of life. Principally, this differs from evaluation of the factual and the observed, which draws on the GP’s professional discretion.
Accountability, Molander argues, means that the reasoning behind the assessments must be available to others for alternative reasoning. Discretions based on ‘tacit knowledge, intuition, holistic thinking (…), receptiveness, and many other things…generate non-public reasons (…) that cannot be validated by others’ (Molander, 2016). Access to the reasoning and argumentative warrants is important to the decision-makers (and no less to the patient whom the document concerns). However, while Molander does not specify what ‘tacit knowledge, intuition, holistic thinking’, etc. are, I argue that such informal knowledge about the patient is an important basis of a GP’s practice that cannot be ignored. The problem, I argue, is not that informal knowledge influences the GP as a certifier, but that such knowledge is not acknowledged as such and is not explicitly included in the certifiers’ reasoning.

10.2 The patient integrity problem

Within the National Insurance scheme, the user perspective corresponds to the patient-centred method in medical practice in which the patient’s attitudes, worries, and expectations are included in the planning of treatment and medical measures. User involvement is organised through the legally based (and obligatory) user panels and committees attached to NAV offices. In 2015, only 65% of the NAV offices had one, and of these, no more than one third worked ‘well’ or ‘very well’ (Hilsen and Skinnarland, 2015). This may indicate that user involvement is also poorly developed on an individual level.

In spite of the legitimacy of the patient’s right to raise claims for benefits, and his/her obligation to be involved in and to participate in the processing of DB (aiming at a work-first priority), the patient’s voice has no formal legitimacy in the representation of work incapacity. In practice, the patient’s voice must be modulated, adapted, and represented by the GP into a medical language that must be comprehensible to the NAV official. This is why the medical language must not only be trustworthy and truthful, and it must also speak with the authority of the medical profession, that is, in a way that displays that the speaker’s insight is based on authorised, specific knowledge and competence sanctioned by law.
(Måseide, 1991). However, the results of our textual analysis indicate that the physicians’ authorised, specific knowledge and competence might be warrants neither for “true” descriptions of the patient’s reality nor for writing good certificates. Specific medical knowledge is rarely sufficient to explain work disability, and the physician’s authority in a dual role is questionable. The GP’s formal competence beyond medical knowledge is limited, and this should be recognised by leaving some space for the patient’s own documentation of his/her state of health and functioning.

11 FINAL COMMENT: HUMANISING THE WELFARE

In this chapter, I suggest and discuss some alternatives related to patient involvement with respect to the medical certificates. The proposals aim to

- Increase the patient’s involvement, responsibility, and autonomy in the DB processing.
- Ensure the patient’s integrity and protect her/him against intrusion into his/her private life-world.
- Provide the patients’ voluntary, adequate, and pointed information about his/her own health and life conditions.
- By these measures, restrict the discretionary scope of the physician as a certifier and confine it to giving information and evaluations of diagnosis, personal examination, treatment, and – if possible – prognosis, all based on evidence.
- Provide the NAV with clear information that leaves no doubts about their sources.

11.1 What can we do to improve medical certificates and the GPs’ working conditions as experts?

Across countries, there are calls for a political focus on GPs’ responsibilities. Better support from other stakeholders (Hussey et al., 2003), increased co-
operation, and more active dialog between the NAV and GPs in assessing work capacity (Lima and Nicolaisen, 2016) are among the propositions for improvement. When GPs have taken measures to increase their occupational health competence it has been found to increase GPs’ confidence in their work ability assessments (Money et al., 2010; Mandal and Dyrstad, 2017).

More explicit and clearer guidelines are suggested by some researchers for improving the certificates (Lima and Nicolaisen, 2016), and the use of the WHO’s International Classification of Function (ICF) has been proposed (Nilsing et al., 2012; de Boer et al., 2008; Willems and de Kleijn-de Vrankrijker, 2002). This might restrict the physician’s discretionary freedom to some extent, and may not be fully adequate in ‘selecting the right people’ for DB, as claimed by de Boer. Solli and Barbosa da Silva have argued that the ICF claims to be holistic but that its ontologic grounds are ‘materialistic’ and fail to address the ‘multidimensional view of the human being’ (Solli and Barbosa da Silva, 2012).

Withdrawing the certifying task from the family physician and reducing the importance of the GP in processing DB has been implemented in many OECD countries (OECD, 2006; OECD, 2010; Higgins et al., 2014). In Norway, however, the GPs’ dual role has never been a political issue of significance, and rather than disqualifying them as experts for the NAV, they ‘have been subjected to further education by the NAV.

In their criticism of the NAV form, some authors have suggested a more patient-as-a-person-oriented outline and a stronger emphasis on the claimant’s abilities and resources (Aarseth et al., 2014). Solli and Barbosa da Silva propose the principle of a comprehensive concept of cognitive objectivity (CCCCO) that includes a description of the patient’s social context and recognizing the patient’s perspective and applying epistemological principles (professional expertise, dialogical intersubjectivity, impartiality, accuracy, and correctness) (Solli and Barbosa da Silva, 2018).

There is no evidence in Norway that changes within one single area will actually lead to better certificates. There is a need for reforms within several fields in order to adjust the GPs’ task as certifiers to an adequate level, to
increase their qualifications as writers, to legitimise the patient’s documentation power, and to widen the scope of factors that might be relevant to assessing work ability and capacity. Such reforms might in part demand necessary changes to the National Insurance Act.

11.2 The claimant – a legitimate, subjective voice.
In this chapter, I discuss alternatives to the GP’s authoritative representation of the patient, aiming at increasing the patient’s self-representation in the processing of DB.

To counter paternalism and depersonalisation and to open to the direct participation of the patient, we suggest that every individual (when feasible, and with or without the co-operation of the GP) should have the formal right and obligation to represent themself and their own relative functional loss in the certificate text, describing her/his abilities within major fields of life in a particular document and clarifying how they are related to the loss of work capacity. This would be expected to position the claimant as an actor with the right to speak for themself, and we consider the right to represent oneself as a first step toward patient-centredness.

In addition, complete and accurate medical certificates are needed in order for them to be a good basis for decisions. Being complete, I argue, involves the inclusion of the patient’s subjectivity. I suggest introducing a division of labour between the doctor and the patient in which the patient – when this is feasible – participates on equal terms as a formal and legitimate co-author of the certificate. A practice of patient self-representation of symptoms and aspects of his/her functionality and work capacity might principally ensure sufficient information and increase the quality of the certificates so as to make them a better basis for decisions. I also believe that self-representation grounded in the patient’s subjective contingency (subjectivity is the very point of it) and in the patient’s own words (with or without assistance), would safeguard the patient’s integrity and autonomy. The patient would have the right to select, prioritise, or limit information about their health, private life conditions, functionality, and work ability as part of the certificate. This might result in an adequate and relevant
picture of what the patient finds most important in their life situation with regard to work and health.

Giving the patient the right to a voice of their own in the text of medical certificates of work incapacity might, I argue, also elevate their status from being a passive claimant to the status of a co-responsible actor.

Principally, the introduction of the patient’s voice into the text as a juridical and legitimate part of the text is not a new idea. People’s purchase of insurance through private insurance companies, applications for driver’s licenses, and many other juridical and social rights are commonly based on the applicant’s responsible self-reporting of health in addition to the physician’s declaration.

In today’s medical practices, exploring the patient’s experience of illness, taking the patient’s perspective, and caring for the patient’s autonomy are ideals. In a life-world of unexplained complaints and symptoms, of “subjectivism”, the physician should still have the patient’s experience in mind, not to take over the patient’s perspective, but to relate to it as a separate linguistic room and as a quality in its own right that is distinguished from the physician’s perspective.

The medical versions of patients’ trajectories, namely the patient records or case histories, might not only ignore important, complex parts of the patient’s history, but might also disguise the ambiguity, the uncertainty, and the ad-hoc character of medical practices (Berg, 1996) and, I would argue, of the medical certificates.

There will be patients who, for different reasons, are not capable of representing themselves in text in order to document their illnesses and functionality. To provide them the possibility of self-representation, special rules safeguarding assistance in self-representation should be a legally protected right.

11.3 The GP, the professional voice
A number of studies have shown that many GPs acting as experts see their role as the patient’s advocate to be unproblematic and important. Sympathy for the patient is highly legitimate, and “putting the patient first” is a legacy and a
professional axiom; however, this might come into conflict with other commitments in a number of circumstances (Beauchamp and Childress, 2013).

When the patient’s subjectivity has become as legitimate as the physician’s professional evaluations, but separated from these, the physician might be able to replace advocacy with his/her professional perspective. Instead of biased or unclear information, vague and ambiguous language, unreasoned causal connections, paternalism, and appeals to the reader, the certifier’s text might focus on providing and explaining the results of clinical examinations, describing outlines and treatment, giving well-reasoned evaluations of prognosis, and relating the patient’s information to the clinical findings. The physician’s statements might thus put the patient’s information into a comprehensible context without the GP submitting to advocacy. This is not to say that medical findings and the interpretation of them are not revisable, and other physician might evaluate medical findings differently, but they will be accountable on the grounds of accessible reasoning. Strategic or biased writing will most probably never be completely eradicated, but within a restricted scope of discretion it might be reduced significantly.

The two narratives (the patient’s and the physician’s) can be seen to exist on an equal basis but with different perspectives that together provide complete information, as suggested by Montgomery (Montgomery, 1991). A legal division of labour between the two actors, I believe, might reduce the influence the patient has on the GP’s execution of their expert role, reduce physician-patient tension and conflictive potentials, and most probably create a better working situation for the GP.

Some might argue that confining the GP’s certifying task would mean a return to a reductionist and biomedically oriented position for the physician. This is not the intention of my suggestion – and a certifier is best qualified when he/she has broad knowledge about the patient’s context and work situation. This knowledge, however, is best provided by the patient (and perhaps also his/her employer). What the certifier needs to do is to relate the patient’s self-represented information in the evaluations of the medical findings. The institutionalised
hybridisation of the GPs’ task as certifier, as is presently the case, seems to affect their roles as experts negatively.

11.4 To the NAV: more clarity

From the NAV’s point of view, including the patient in the writing would contribute to implementing the patient’s active involvement and responsibility in processing DB (and other benefits related to health). It might reduce the processing time due to increased clarity of the informational sources. One would neither have to speculate about the distinction between “subjectivity” and “objectivity” in the description of illness and functionality, nor about the sources of information in the certificates because they will have been assigned to two separate and different “spaces” – the patient’s and the physician’s.

Some might argue that even though the physician’s information is confined to medical reasoning, one cannot have full trust in the claimants’ self-representation because there are also among them malingerers and scammers. I argue that the justification for the patient’s self-representation, in addition to what is already mentioned, lies in its legitimacy being equal to the physician’s. “Equal” in this context, means that the patient’s report is subjected to the same assessment based on verification and relevance as is the GP’s documentation because it is given the same legal status. The two are separated textually, but are read, interpreted, and understood in relation to one another.

It is puzzling that the NAV requires that the patient be enrolled in a 3 to 4-year programme to have his/her abilities and working capacity assessed by trained staff, and yet still leans so heavily on the GP’s medical expertise (Lima and Nicolaisen, 2016; Gjersøe, 2017). It is a paradox that a diagnosis is still a legally obligatory condition for benefits, while the patient’s functionality is considered decisive, irrespective of diagnosis. Diagnosis is provided by the GP who, however, regularly insufficiently describes the patient’s functionality or omits it entirely. By adding the patient’s legal and authorised self-representation, there is a better chance that psychosocial factors might contribute to seeing the
patient’s situation with a holistic gaze, but based on a relevant and balanced selection of such information.

I do not see that GPs *qua experts* should embrace “the whole context” of the claimant. Considering the danger of conflicting with legal and democratic predictability and rights, and the danger of harming the patient’s integrity and private life-world, there are fields within the patient’s context that should – as a point of departure – be “hands off” for the doctor and should be for the patient to decide whether to display or to withhold. The GP is an expert with legitimate, but limited, professional authority and should operate within that field. Together with the patient’s self-representation and the work condition reports from the work trainer, this might make the medical certificate a more accurate, reasonable, and predictable basis for decisions within the welfare scheme.

Eventually, I suggest that the NAV form should be edited and adapted to include the claimant’s perspective of illness, independent of diagnosis. The medical report should have a separate form or space and should not “pass” without evidence, which will probably create a more realistic and professionally sincere basis for the GP’s task as a certifier.

### 11.5 Learning to write as an expert

One of my questions arising from reading the literature on GPs’ experience with medical certificates was, if GPs struggle with uncertainty about how to evaluate the effect of illness on functionality and work fitness, or with disagreeing with the patients – and yet still have to perform the task of certifying – how might this discrepancy possibly be reflected in the texts?

Guidelines and rules for textual practices are useful, but the complexity of language and the nearly endless variation in the use of grammar and words offer the writer a textual freedom to use vague, subtle, and ambiguous language that might not technically deviate from the guidelines. Thus, advocacy and unreasoned assessments might lead to unfair decisions.

The patient who applies for DB never meets the decision-maker face to face, but is represented by the medical certificate (and other documents in the case) that functions as an independent *social actor* in the processing of DB.
Consequently, professional writing skills should be validated as an important part of physicians’ skill and practice and should be taught in medical schools, preferably involving humanities professors.

The importance of seeing medical texts such as certificates and scientific articles as actions or strategies in themselves can hardly be overestimated. Medical certificates influence what kind of decision-making is being performed, and in the case of DB it is a question of large sums of money and a fair and predictable distribution of welfare resources.

Medical certificates are part of the discoursal expertise of medicine. They need to cease being an “orphaned field” so that future physicians can be conscious about how they write and to what effect. In this thesis, I have referred to a number of proposals for changes from other researchers, and I have proposed alternative ways of gathering information to construct a good basis for decisions of DB. The proposals aim at strengthening the integrity of the patient as well as that of the GP by providing sincere and truthful information based on reasoning and evidences. There is, however, no evidence that any single measure to be taken would improve medical certificates in any substantial way. Writing medical certificates is an activity that is exerted within a complex field consisting of the doctor-patient relationship, vague concepts of disease and work ability, and – in Norway at least – strong GP autonomy. I believe, though, that increased patient involvement and responsibility and the legitimate enrolment of the patient’s voice on an equal basis will make the physician’s role clearer, more confined, and less conflicted.
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Pressemelding nr: 30


Solli HM, da Silva AB and Egeland J. (2014) Usefulness of an ability-based health model in work ability assessments provided by psychiatrists and psychology specialists writing social security certificates. *Disability and Rehabilitation* 37: 571-578.


St.meld. nr 9 ( 2006-2007) *Arbeid, velferd og inkludering.*


APPENDIX 1 (article 3):

Results of appraisal analysis grouped into five main themes, article 3

THEME 1: The DB processing within NAV worsens the claimant’s health

1. ‘He is still marked (affect, negative: unhappiness/dissatisfaction) by the long struggle (with NAV) against being disbelieved; it is hard (affect, negative: displeasure) for him having to explain everything again to a new GP’.
2. ‘Due to a stressful (affect, negative: unhappiness) and long-lasting (appreciation, negative: overdue) process, she has become depressed (affect, negative: unhappiness) and anxious’ (affect, negative: insecure)
3. ‘After ten years of treatment without improving his health, he does not feel ok (affect, negative: misery, unhappiness, etc.) at all’.
4. ‘His afflictions are mostly of a subjective (appreciation, negative value: not qualified) kind and hence there are no objective (appreciation, positive value: qualified) findings by which to assess his working capacity.
   All previous measures taken to resume work have been unsuccessful (appreciation: neg. value: ineffective). He struggles (affect, negative: insecurity, unhappiness) with real problems, and with being understood so that he can get sufficient help’ (pos. social sanction: veracity, honesty).

THEME 2: The patient “deserves” DB for possessing values that are “NAV-specific”, and for having values accepted as universally positive.

1. ‘If she pushes herself or tries to do things (pos. social esteem: tenacity, capacity, will to activate) she gets worse. She has held herself back (pos. social esteem: tenacity; pos. social sanction: veracity, credibility) from applying for DB, even though it has been a probable (modality: writer’s evaluation) outcome for many years. She now applies for permanent DB, which seems (entertain, dialogically expansive) reasonable (appreciation, positive); there is no opportunity for her to work in foreseeable future’
2. ‘He has a few good (appreciation, positive) days now and then, thinking that he might have been working then (pos. social sanction: veracity; moral, will
to work). But then, the next day, *it will again be impossible for him*’ (pos. social esteem: blamelessness).

3. ‘*Struggles* (affect, negative: insecurity, unhappiness) with his motivation due to pain in hips, knees and back, but *at the same time he wants to stay in job*’ (pos. social sanction: veracity, a will to work)

4. ‘The patient *has been fighting* throughout the years *to stay in work as much as possible*’ (pos. social esteem: tenacity; positive social sanction: honesty, a will to work)

5. ‘She still has changing levels of myalgia, but is now familiar with them and *masters them well*’ (pos. social esteem: capacity, having control, mastering abilities)

6. ‘He *does not want* (reported speech, attribution) to be treated with addictive pain-killers’ (pos. social esteem: tenacity).

7. ‘[He is] a *positive fellow* (pos. social esteem: capacity, mentally sound) who looks forward to get into work and be useful to society’ (pos. social sanction: good moral, will to work). Mentally and emotionally he is *doing well* (pos. social esteem: capacity, sound).

8. ‘She is *good* at keeping herself active’ (pos. social esteem: capacity, healthy; tenacity, persevering)

9. ‘The patient *wishes* (reported speech, attribution; acknowledged, dialogically contractive) to keep his 40 % part-time work as self-employed (pos. social esteem: a will to work)

10. ‘He *is motivated* for his own health’ (pos. social sanction: sincerity) ‘He has paid with his own money (pos. social esteem: tenacity; a will to sacrifice) for physiotherapy, acupuncture and several MRIs to *prove* (pos. social esteem: tenacity) that he has physical, medical problems that cause pain’.

**THEME 3: Low social esteem: DB will make life better for the patients.**

1. ‘She is still *having problems with meeting at the time agreed* (neg. social esteem: capacity, not reliable). She is *unconcentrated, “uneasy” or hectic* (neg. social esteem: low capacity, low tenacity), has a *positive attitude* (pos.
social sanction: veracity), but has **reduced ability to implement** (neg. social esteem: low capacity, low tenacity). Bothered by pain. She is **easy to divert** (neg. social esteem: tenacity low). [I] request NAV to assess her eligibility for DB. **It is difficult** (Appreciation: negative. Writer’s stance: objectifying, dialogically expansive) to see that she has any chance of getting a work. **I am uncertain** (writer’s subjectivity, dialogically expansive) about **how she manages her economy’** (writer’s stance, suggesting neg. social esteem: low capacity, incompetence)

2. ‘**Alcohol directs her life’** (neg. social esteem: low capacity)

   The patient **should have** 100 % DB (writer’s stance, modality: obligation). It is **possible** (modality, hedging; writer’s low commitment) for her to get an “**engagement**” (quotation marks: vague language, hedging) by the local AA and this **will be** (epistemic modality, hypothetical/irrealis)very good (appreciation) for her. **Not least** (grading up) to her **self-esteem** (affect attributed to the patient). It **could** (modality; hedging; dialogically expansive) also, **to some extent** (hedging by grading), act as a deterrent to her alcoholism’

**THEME 4: Granting DB at the patient’s wish or as a pragmatic solution.**

1. ‘The patient **claims** (reported speech: dialogically expansive) to have extensive and intense (grading up) pain that prevents him from resuming work’. He **claims** (reported speech: dialogically expansive) to be tired and exhausted (affect) and that he cannot do any kind of work. **One has not managed, for more than ten years, to get the patient back to work, and hence, permanent DB should be** (modality: obligation) evaluated’.

2. ‘The patient has tried various (grading up) measures to resume work, but – according to **his saying** (reported speech; dialogically expansive) – he had to break because of “**bad health**”’ (vague language: quotation marks; hedging). ‘Now **he wants** (reported speech, dialogically contractive) to have DB’.

3. ‘**The patient does not consider it possible** (reported speech; dialogically expansive) to resume work, due to his chronic back pain’.

4. ‘The patient works in a small company where making **special** (appreciation negative: irregular) adaptions is **difficult** (appreciation, negative: not
sustainable). Granting him DB by 50 %, therefore, seems (entertain; dialogically expansive) appropriate (appreciation, positive: balanced) to maintain a residual capacity of work’ (social sanction, positive: will to work).

5. ‘It seems (entertain; dialogically expansive) most realistic (appreciation, positive valuation: balanced) that she be granted DB by 100 %’.

THEME 5: Addressing the reader through authoritative statements and negotiations.

1. ‘There is a clear causal relation (objectifying, bare statement; dialogically contractive) between the patient’s afflictions and her reduced working capacity’.

2. ‘It is recommended (objectifying; dialogically contractive) that temporary DB is prolonged’

3. ‘He is 100 % work incapacitated’ (bare statement: dialogically contractive).

4. ‘I see (writer’s subjectivity; dialogically expansive) no reason why he should continue rehabilitation or courses. The patient must have (modality, obligation; subjective, dialogically expansive) DB now’.

5. ‘I consider (writer’s subjectivity, dialogically expansive) that further investigation of her psychic afflictions will not shed new light on her troubles. Most probably (modality, highly graded), she must live (modality, inclination; dialogically expansive) with them and accept them.’

6. ‘One must now realise (objectifying; modality: obligation) that there is no real chance for her of resuming work. She is now recommended (objectifying) to apply for DB’.

7. ‘(…) after more than 10 years of treatment without significant improvement of his health, I see (entertain; writer’s subjectivity; dialogically expansive), no reason why he should continue with rehabilitation/courses’.

8. ‘The patient should get (modality, obligation; dialogically expansive) a 100% disability benefit’.

9. ‘The undersigned does not see (writer’s subjectivity; dialogically expansive) that the patient has any residual (appreciation) work capacity’.

10. ‘A DB by 60 % will not be (modality; dialogically expansive) unreasonable’ (appreciation, positive valuation: appropriate).
11. ‘The specialist thinks (reported speech; dialogically expansive) that he should have (modality: necessity) at least (grading up) 50 % DB.’
APPENDIX 2: Legeerklæring ved arbeidsuførhet, side 1-3

<table>
<thead>
<tr>
<th>0 Erklæringen gjelder</th>
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<tbody>
<tr>
<td>0.1 Arbeidsavvurdering ved sykefravær</td>
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</table>

<table>
<thead>
<tr>
<th>1 Opplysnings om pasienten og om arbeidsforhold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Etternavn, fornavn</td>
</tr>
<tr>
<td>1.4 Adresse, postnummer og poststed</td>
</tr>
<tr>
<td>1.5 Arbeidsgiverens navn og adresse</td>
</tr>
<tr>
<td>1.7 Er pasienten kjent?</td>
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<table>
<thead>
<tr>
<th>2 Diagnose og sykdomsopplysninger</th>
</tr>
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<tbody>
<tr>
<td>2.1 Hoveddiagnose(er)</td>
</tr>
<tr>
<td>2.2 Bil-diagnose(er)</td>
</tr>
<tr>
<td>2.3 Sykthusiastie med symptomer og behandling</td>
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<table>
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<tr>
<th>2.5 Status pros. (angi dato): Resultat av relevante undersøkelser</th>
</tr>
</thead>
</table>
| 2.6 Bør NAV-kontoret vurdere om det er en ...
  2.7.1 Ytrekskade/Ykersykdom?  
  2.7.2 Ev. skadedyte |

NAV 08-07.08 Bokmål. Fastsatt: 10.99. Endret: 03.2010 (Side 1)
3 Plan for medisinsk utredning og behandling

3.1 Er pasienten henvis til utredning? Spesifiser

3.2 Utredningsplan: Oppgi planlagte undersøkelser og tidspunkt/variabel

3.3 Behandlingsplan: Oppgi planlagt behandling og tidspunkt/variabel

3.4 Ny vurdering av tidligere utrednings-behandlingsplan

3.5 Når er det hensiktsmessig, i forhold til utrednings- og behandlingsopplegget, at NAV-kontoret bør om nye leggeopplysninger?

3.6 Hvis videre behandling ikke er aktuelt, gi begrunnelse.

4 Forslag til tiltak utover medisinsk behandling

4.1 Er det ut fra en medisinsk vurdering aktuelt med noen av følgende tiltak nå?

4.2 a) Kribe av
b) Helsebærekost

4.3 arbeidsavklaringspenger

c) Aktiv

d) Hjelpemidler på

e) Arbeidsavklarings-

f) Friskmelding til

penger

g) Andre

Hvis ja, oppgi ev. begrunnelser i forhold til tiltak, hva nei, gi begrunnelse.

5 Medisinsk begrunnet vurdering av funksjons- og arbeidsevne

5.1 Beskriv hvordan funksjonsevnen generelt er nedsatt på grunn av sykdom

5.2 Er pasienten i inntektsgivende arbeid, hjemmearbeidende, student eller annet?

Beskriv kort type arbeid og hvilke krav som stilles.

5.3 Vurdering av arbeidsevnen

Vil pasienten kunne

a) gjennomføre det tidligere arbeidet?

b) Ikke annet arbeid

Hvis ja

5.4 a) Hva kan pasienten ikke gjøre i det nåværende arbeidet?

b) Hvile andre hensyn må eventuelt tas ved valg av annet yrke/Arbeid?
6 Prognose

a) Antas behandlingen å føre til bedring av arbeidsevnen?
   Ja       Nei

b) Anslå varigheten av sykdom, skade (ev. lyte)

c) Anslå varigheten av funksjonsnedsettelsen

d) Anslå varigheten av den nedsatte arbeidsevnen

7 Årsaksammenheng

Anslå hvor stor betydning funksjonsnedsettelsen har for at arbeidsevnen er nedsatt

8 Andre opplysninger


9 Samarbeid/Kontakt (9.1 Kryss av for den du ønsker NAV-kontoret skal ta kontakt med)

<table>
<thead>
<tr>
<th>Behandl. lege</th>
<th>Arbeidsgiver</th>
<th>Basissone</th>
<th>Annen instans (hva)</th>
<th>9.2 Ønsker du kopi av vedtaket?</th>
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</table>

10 Forbehold

10.1 Er det noe i legesetrinnet som pasienten ikke bør få vite av medisinske grunner?  
Hvis ja, oppgi hva pasienten ikke bør få vite  
   Ja       Nei

11 Legens underskrift mv.

11.1 Dato, legens navn og adresse

11.2 Legens underskrift

11.3 Telefonnr.
APPENDIX 3: Medical certificate for work incapacity (NAV 08-07.08)

(translated version used in the articles. Translated by: Guri Aarseth)

NATIONAL INSURANCE
Medical Certificate at Work disability

The physician is to send this to the local NWL office

0. This certificate is about
   0.1 Evaluation of work capacity at sickness absence
   0.2 Rehabilitation money
   (0.3)
   0.4 Disability pension

1.0 Information about the patient and employment status
   1.1 Family name, first name
   1.2 Date of birth, identity number
   1.4 Address
   1.6 Employer’s name

2.0 Information of diagnosis and disease.
   2.1 Main Diagnosis (s)  2.1.1 Diagnosis Code (2.3 Code system)
   2.2 Secondary diagnoses  2.2.1 Diagnosis Code
   2.4 Completely incapacitated since (date)
   2.5 History of the disease, symptoms and treatment
   2.6 Current clinical status (specify date of examination). The results of relevant investigations.
   2.7 Should NWL consider whether it is 2.7.1. an occupational disease? (Yes / no)
   2.7.2 If so: date of loss

3.0 Plan for medical investigation and treatment
   3.1 Is the patient referred to medical investigation (specify), treatment (specify)
   3.1.1 Date of referral to medical clarification 3.1.2. Expected waiting time
   3.1.3 Date of referral to medical treatment  3.1.4 Expected waiting time
   3.2 Plan for medical examination. Specify the planned examination and time/duration.
   3.3. Plan for medical treatment. Specify the planned treatments and time/duration
   3.4 Re-evaluation of previous plan of examination and treatment.
   3.5 When is it appropriate that NWL office, concerning clarification and treatment program, requests new medical information?
   3.6 If further treatment is not relevant, give justification
4.0 Proposed measures beyond medical treatment

Are the following measures applicable, on a medical basis? Yes / No

If yes, which ones? → (Reply to points a- g: a) support for extraordinary health services, b) transport assistance to work, c) active sick-leave d) devices for help in work, e) rehabilitation money, f) reference to the Employment Service Office, g) others (which ones?)

If yes, list the constraints on the patient’s capacities.
Add supplying information.

If no, give justifications.

5.0 Medical assessment of the patient’s functions and work ability.

5.1 Describe how the patient’s functioning is generally reduced due to disease.

5.2 Is the patient employed, home working, student, other? Specify
Briefly describe the type of work and the requirements

5.3 Assessment of working capacity.
Will the patient be able to
a) resume previous work- No /yes? If yes: soon/after treatment?
 b) do other kinds of work- No/Yes? If yes: soon/after treatment?

5.4 a) What is it that the patient cannot do in the present work?
b) What other possible considerations need to be made in choice of another profession / work?

6.0 Prognosis

a) Is the treatment assumed to improve the work ability? Yes / No:
b) Estimate the duration of disease, injury
c) Estimate the duration of the declined functionality
d) Estimate the duration of the declined working capacity

7 Causation
Estimate the degree of significance of the functional disability to the reduced working capacity.

8 Additional information (optional)

9 Cooperation / Contact
9.1 Select the one you want the NWL office to contact: the treating physician/employer/NWL/others.

10 Reservations
10.1 Is there anything in the statement that the patient, for medical reasons, should not get to know? If yes, specify what the patient should not get to know.

11. Date. The name, the phone number, the address and the signature of the physician.
**ERRATA LIST:** Guri Aarseth.

Title of thesis: The language of work disability. A study of medical certificates written by Norwegian general practitioners

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<td>1 1.1.1 why study medical certificates?</td>
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<td>19 … as illustrated in Figure 2.</td>
<td>Cor</td>
<td>…as illustrated in Figure 3.</td>
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<td>55 (new:56)</td>
<td>4 ..according to age, region, and diagnosis</td>
<td>Cor</td>
<td>…according to age, sex, region and diagnosis</td>
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<td>Cor</td>
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<td>69 (new: 74)</td>
<td>5 …or even recognise, achievements…</td>
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<td>Adapted to fit alphabetic order.</td>
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‘Working is out of the question’: a qualitative text analysis of medical certificates of disability

Guri Aarseth1*, Bård Natvig1, Eivind Engebretsen2 and Anne Kveim Lie3

Abstract

Background: Medical certificates influence the distribution of economic benefits in welfare states; however, the qualitative aspects of these texts remain largely unexplored. The present study is the first systematic investigation done of these texts. Our aim was to investigate how GPs select and mediate information about their patients’ health and how they support their conclusions about illness, functioning and fitness for work in medical certificates.

Methods: We performed a textual analysis of thirty-three medical certificates produced by general practitioners (GP) in Norway at the request of the Norwegian Labour and Welfare Administration (NAV). The certificates were subjected to critical reading using the combined analytic methods of narratology and linguistics.

Results: Some of the medical information was unclear, ambiguous, and possibly misleading. Evaluations of functioning related to illness were scarce or absent, regardless of diagnosis, and, hence, the basis of working incapacity was unclear. Voices in the text frequently conflated, obscuring the source of speaker. In some documents, the expert’s subtle use of language implied doubts about the claimant’s credibility, but explicit advocacy also occurred. GPs show little insight into their patients’ working lives, but rather than express uncertainty and incompetence, they may resort to making too absolute and too general statements about patients’ working capacity, and fail to report thorough assessments.

Conclusions: A number of the texts in our material may not function as sufficient or reliable sources for making decisions regarding social benefits. Certificates as these may be deficient for several reasons, and textual incompetence may be one of them. Physicians in Norway receive no systematic training in professional writing. High-quality medical certificates, we believe, might be economical in the long term: it might increase the efficiency with which NAV processes cases and save costs by eliminating the need for unnecessary and expensive specialist reports. Moreover, correct and coherent medical certificates can strengthen legal protection for claimants. Eventually, reducing advocacy in these documents may contribute to a fairer evaluation of whether claimants are eligible for disability benefits or not. Therefore, we believe that professional writing skills should be validated as an important part of medical practice and should be integrated in medical schools and in further education as a discipline in its own right, preferably involving humanities professors.

Keywords: Norway, GP, Medical certificates of incapacity for work, Document analysis
Background
Physicians are producers of texts, although they are probably not inclined to consider themselves as such. Written reports go hand in hand with clinical work, as they have since the Hippocratic writers communicated their clinical observations in case reports. In Europe, the medical case report was refined and ‘purified’ during the 18th and 19th centuries, becoming a professional skill in its own right [1, 2]. In our time, society relies on medical texts to approve, testify to, and document nearly everything that can be related to ‘health’. Accordingly, the amount of administrative documentary work that doctors must perform is increasing at the expense of their clinical work [3]. In doing this work, physicians are supposed to exit the mode of treating doctor and take on the role of expert, balancing the perspectives of professional sympathy and impartiality [4].

A certificate – from the Latin certificare, meaning to guarantee as certain or attest in an authoritative manner (Oxford English Dictionary) – verifies facts; a medical certificate, in particular, attests to the condition of a person’s health. It can be used to legitimise benefits to compensate for loss of income as the result of disease, or to exempt or relieve a person from his/her normal activities. In this article we examine medical certificates written by Norwegian GPs, taking disability benefits as our point of departure. Our aim is to investigate how these physicians, when acting as experts, mediate their patients’ illnesses, functioning, and fitness for work and how they report assessments made on a medical basis. Our purpose is to encourage a discussion about the role of GPs in the disability benefit scheme and address the need for a systematic incorporation of writing instruction in medical schools and in further education.

Medical certificates play a crucial role in allocating benefits in welfare states. To be legal, a medical certificate must generally be issued by authorised health personnel. The authority of the document depends on an authorised reader sharing the perception of its factual veracity [5]. A certificate must provide verifiable information; the certificate must be accurate, not misleading or flawed, and should be written based on the physician’s recent, personal examination of the patient.

In Norway, according to the National Insurance Act, a medical certificate of disability must make probable the patient’s illness, their loss of function, and their need for permanent income compensation [6]. In issuing these certificates, therefore, GPs have to navigate a problematic landscape in which persistent complaints, symptoms, and illness, with or without objective correlates, must be subjected to the certificate’s professional reasoning. GPs recognise that they have little knowledge about patients’ workplaces, their functioning, or their working capacity [7–12]. In addition, formal medical knowledge may be insufficient as a basis for determining individuals’ rights and eligibility for social benefits [7].

Arthur Kleinman [13] defines illness as the ‘innately human experience of symptoms and suffering’, disease as the practitioner’s ‘recasting of illness in terms of theories of disorders’, and sickness as the understanding of a disorder (for instance tuberculosis) across a population in relation to macrosocial forces (poverty, education etc.). In contrast to this English triad, the Norwegian term sykdom comprises both illness and disease (in the National Insurance Act, sykdom also refers to injury [skade], impairments, and defects [lyte]) [14].

The ethics of issuing medical certificates differ in several respects from those of producing clinical documents. First, the information contained in a certificate is, in part, exempt from obligations to protect patient confidentiality. Second, whereas as therapists physicians are expected to always consider the best possible outcome for their patients, as experts they should act according to criteria of objectivity. In other words, physicians should provide information that is impartial, correct, verifiable, and accurate, [4], and act ‘without regard to the outcome of the case’ [15]. Moreover, physicians should not be passive mediators of the patient’s concern and utterances, but act as a ‘performer of the profession’ [4].

The ethical and professional dilemmas of physicians facing the discourses of both law (including the gatekeeper function of the doctor) and medicine are treated in studies of GPs’ practices of certifying sick leave [16–19]. In a questionnaire survey, Gulbrandsen et al. [20] found that it is not uncommon for Norwegian GPs to provide medical certificates strategically written in favour of the patient; however, the GPs in that study claimed that they were not twisting the facts or lying, but rather using discretion and argumentation. Other investigations have indicated that GPs may be directed by advocacy and the patient’s subjective needs and wishes when issuing sickness certifications [17, 21, 22], as well as by their own personal values and attitudes [23], personality, and beliefs [24].

Direct investigation of the content of certificates is scarce, but Kiessling et al. [25] found that 90 per cent of a selection of Swedish medical certificates lacked relevant or adequate information about the patient’s ability to function and capacity to work; others have shown that ambiguous statements about a patient’s medical disorder are not uncommon [26]. In a previous article we presented a linguistic analysis of the same medical certificates of fitness to work which showed that certifying GPs tended to emphasise the patient or claimant principally as a passive carrier of symptoms with little or no agency [27]. The above studies indicate that ambiguities, possible biases, and a lack of relevant information may
undermine the validity of decisions made on the basis of medical certificates.

In addition, officials processing disability benefits cases within the Norwegian Labour and Welfare Administration (NAV) experience that deficient or unclear information in GPs’ medical certificates can lead to costly and time-consuming delays [28]. In such cases, additional information needs to be obtained; this information is increasingly (though probably unnecessarily) ordered from specialists charging significantly higher fees. Because the specialist needs to see the claimant personally and write a new note, it usually leads to an increase in the case’s processing time, sometimes by several months. The delay creates temporary uncertainty for the claimant as to the outcome of the proceeding.

Compared to GPs in some other European countries, GPs in Norway play a prominent role in assessing patients’ health-related inability to work [29] and, thus, are highly influential in the distribution of public resources. Their importance can be illustrated by the fact that presently 9.5 per cent (317 700) of the population between 18 and 66 years of age [30] are living on disability benefits. Altogether, the largest group of benefit recipients – 63 per cent – have been diagnosed either with diseases related to the musculoskeletal system (mainly low back pain and fibromyalgia) or with mental disorders (mainly anxiety and depression) [31, 32]. The government estimate of the total costs of working disability benefits in Norway in 2016 was 78.2 billion NOK (£8.55 billion) [33]. Decisions on disability benefits are taken by non-medical officials in the regional offices within NAV, who never meet the claimant personally and must rely entirely on textual information about that person.

In this article, using narratological and linguistic analysis, we examine a sample of texts written by GPs in their role as experts to determine how they communicate the illness, functional ability, and working capacity of people claiming disability benefits.

Methods

Data collection

Our material consists of medical certificates of incapacity for work produced by Norwegian GPs. They are, with one exception (which was written by freehand), written on a standardised form, the Medical Certificate of Disability [34]. The certificates were collected in the period March–June 2013; all of them were written between 2007 and 2013. At the time of collection, the cases had already been assessed and closed by NAV. NAV’s central statistical register of assisted us in selecting 150 potential certificates within four counties in Norway.

We strategically selected individuals based on age, sex, geographic region, and diagnosis. The age range was 18–66 and at least one third belonging to one sex. One third of the certificates fell into the category of musculo-skeletal related diagnoses, one third into the category of psychiatric diagnoses, and the remaining third into the category of other disorders; thus the sample roughly reflects the distribution of diagnoses among the total population of Norwegians receiving disability benefits. The four counties were selected according to the proportion of the population receiving disability benefits: one had a relatively high proportion (>12%), two were in the median (8–12%) and one had a low proportion (<8%).

The project was approved by the Data Protection Official for Research [35], the Directorate of Labour and Welfare, and the Council of Secrecy and Research in the Ministry of Justice and Public Security. An informed consent letter, also approved by the Data Protection Official for Research, was sent to the 150 claimants via their local NAV offices. We anticipated a final number of 30–50 certificates: forty recipients of disability benefits consented to us accessing their medical certificates. Of the forty certificates, seven were excluded as they were either not about disability or not written by GPs. All the documents were anonymised with respect to the claimants. The number of different certifiers (GPs) equalled the number of certificates. The final sample is shown in Table 1. The main and additional diagnoses complied with the ICPC-2 system (International Classification of Primary Care, Second Edition).

Analysis

We apply qualitative document analysis to our empirical data, which consist of textual units formed by the GPs texts and the form text, Medical certificate for work incapacity (Table 2). Our analysis of the medical certificates draws on the discourses of narratology and formal linguistics. As subjects of analysis, documents are not ‘surrogates’ for reality, but are themselves social facts, exchanged as part of a social interaction [36]. Because

<table>
<thead>
<tr>
<th>Geographic region</th>
<th>Regional distribution</th>
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<td>North</td>
<td>12</td>
</tr>
<tr>
<td>Northwest coast</td>
<td>3</td>
</tr>
<tr>
<td>Central South</td>
<td>4</td>
</tr>
<tr>
<td>Central East</td>
<td>14</td>
</tr>
<tr>
<td>Male claimants</td>
<td>20</td>
</tr>
<tr>
<td>Female claimants</td>
<td>13</td>
</tr>
<tr>
<td>Age range of claimants</td>
<td>30–64 (average = median = 45)</td>
</tr>
<tr>
<td>Diagnosis (ICPC-2)</td>
<td>Main: Additional</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>20</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>
documents do not speak for themselves, they must be 'made to speak by the analyst' [36]. Hence, what we are investigating is not the patient but the documentary depiction of the patient, his/her illness and ability to work. Narrative analysis (as a method) investigates structures and techniques of telling, the narrator's perspective (who speaks?), and the consistency of the facts and interpretations the narrator provides. We use linguistic methods of analysis at the word and sentence levels to investigate different types of grammatical connections between sentences and their meaning.

Narratives, Barbara Smith suggests, can be defined simply as 'verbal acts consisting of someone telling

Table 2 Medical certificate for work incapacity

<table>
<thead>
<tr>
<th>National Insurance (NAV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical certificate for work incapacity</td>
</tr>
<tr>
<td>The physician is to send this to the local NAV office.</td>
</tr>
<tr>
<td>0 This certificate concerns:</td>
</tr>
<tr>
<td>0.1 Assessment of work capacity at sick leave</td>
</tr>
<tr>
<td>0.2 Rehabilitation money</td>
</tr>
<tr>
<td>0.3 Disability pension</td>
</tr>
<tr>
<td>1.0 Information about the patient and employment Name:</td>
</tr>
<tr>
<td>Year of birth:</td>
</tr>
<tr>
<td>Certificate written: date</td>
</tr>
<tr>
<td>Employer’s name and address:</td>
</tr>
<tr>
<td>2 Information of diagnosis and disease</td>
</tr>
<tr>
<td>2.1 Main diagnosis</td>
</tr>
<tr>
<td>2.1.1 Code of diagnosis</td>
</tr>
<tr>
<td>2.2 Additional diagnosis</td>
</tr>
<tr>
<td>2.2.1 Code of diagnosis</td>
</tr>
<tr>
<td>2.3 Classification: ICPC-2/ICD-10</td>
</tr>
<tr>
<td>2.4 Completely incapacitated since</td>
</tr>
<tr>
<td>2.5 Story of disease, symptoms and treatment</td>
</tr>
<tr>
<td>2.6 Current clinical status (specify date). The results of relevant investigations</td>
</tr>
<tr>
<td>2.7 Should NAV consider this to be:</td>
</tr>
<tr>
<td>2.7.1 Occupational disease? (Yes/No)</td>
</tr>
<tr>
<td>2.7.2 If yes: date of injury</td>
</tr>
<tr>
<td>3 Plan for medical examination and treatment</td>
</tr>
<tr>
<td>3.1 Is the patient referred for Medical assessment (specify)?</td>
</tr>
<tr>
<td>Medical treatment (specify)?</td>
</tr>
<tr>
<td>3.1.1 Date of referral for medical assessment. 3.1.2 Expected waiting time (weeks)</td>
</tr>
<tr>
<td>3.1.3 Date of referral for medical treatment. 3.1.4 Expected waiting time (weeks)</td>
</tr>
<tr>
<td>3.2 Plan for medical examination. Specify the planned examination and time duration.</td>
</tr>
<tr>
<td>3.3 Plan for medical treatment.Specify the planned treatments and time/duration</td>
</tr>
<tr>
<td>3.4 Re-evaluation of previous plan of examination and treatment</td>
</tr>
<tr>
<td>3.5 When should the NAV office request new medical information regarding work clarification and treatment programme?</td>
</tr>
<tr>
<td>3.6 If further treatment is not relevant, give justification</td>
</tr>
<tr>
<td>4 Proposed measures beyond medical treatment</td>
</tr>
<tr>
<td>Are the following measures applicable, on a medical basis. Yes/No</td>
</tr>
<tr>
<td>If yes, which ones? a) reference to specialist, b) transport subsidy, c) graded sick leave, d) technical aids, f) unemployment benefit, g) others – which ones? Give supplementary information.</td>
</tr>
<tr>
<td>Are there any specific considerations to be made as to these measures?</td>
</tr>
</tbody>
</table>

Table 2 Medical certificate for work incapacity (Continued)

| If no, give justifications |
| 5 Medically reasoned assessment of work ability |
| 5.1 Describe how the patient's functionality is generally reduced because of disease. |
| 5.2 Is the patient engaged in paid work or domestic work, a student, other? |
| Specify: |
| Briefly describe the type of work and the requirements: |
| 5.3 Assessment of working capacity |
| Will the patient be able to a) Resume the earlier work (No/Yes)? If yes: now/after treatment |
| b) Take other work |
| 5.4 a) What is it that the patient cannot do in the present work? |
| b) What other possible considerations need to be taken regarding the choice of another profession/work? |
| 6 Prognosis |
| a) Is the treatment assumed to produce an improved ability to work? Yes/No |
| b) Estimate the duration of the illness/injury. |
| c) Estimate the duration of the functional disability. |
| d) Estimate the duration of the reduced working capacity. |
| 7 Causation |
| Estimate the importance of the functional disability for the reduced working capacity. |
| 8 Optional information |
| 9 Co-operation/Contact |
| Select those that should be contacted by the NAV office: The doctor/employer/NAV/others |
| 10 Reservations |
| 10.1 Is there anything in the certificate that the patient, for medical reasons, should not know? If yes, specify what the patient should not know. |
| 11 The physician’s signature, etc. |
| 11.1 Date, the physician’s name and address |
| 11.2 The physician’s signature |
| 11.3 Telephone number |
someone else that something happened’ [37]. The ‘something happened,’ which Labov and Waletsky call the ‘complication’ of the story [38] and van Dijk calls the ‘worth telling’ [39], is a key concept of narrative. The ‘complication’ or the ‘worth telling’ is an essential event of the story that has an impact or changes stable situations, conditions or life trajectories. Van Dijk, for instance, emphasises events (disease, in this case) that break the established norms (e.g. of being independent and self-supported) and routines (e.g. daily doings), threaten the basic values (e.g. being healthy) and disturb the balance (e.g. abilities and mastering), plans and goals (e.g. relations, work, education) of the story’s protagonist (who may be an individual with a disease).

Events may be related from different perspectives. Smith points to the inherent relativism of narrative: every narrative is a version of some reality, always ‘constructed in accord with some set of purposes or interests’ [37]. Nevertheless, as Petter Aaslestad points out, the ideal starting point of the documentary text is ‘the true event’ as perceived by the narrator [40]. Leaning on the narratological theories of Wayne Booth and Gérard Genette, we distinguish between the ‘historic author’ (the GP), the ‘narrator/author’ (the telling voice in the text) and the ‘implicit author’ (the text’s norm carrier) [41, 42]. The narrator may represent different perspectives: they may be present as the first person narrator (the ‘I’ of the text) who has limited knowledge of the patient, or as an all-knowing, invisible or impersonal speaker. The intentions of the historic author (the GP) may deviate from those of the narrator for several reasons [43]. Therefore, we distinguish between the GP as a treating family physician on the one hand, and as a narrator on the other. This distinction is also considered in Norwegian legal regulations [44].

The author has in mind an addressee – not a particular, identified person, but rather the author’s idea of a reader, or what Wolfgang Iser terms the ‘implied reader’ [45]. The implied reader is anticipated in the text as a set of the addressee’s competences, reactions, and values [43]. In this case of the medical certificates, the implied reader is represented by (unidentified) NAV employees, including the internal medical adviser. The latter is also an authorised reader who shares the knowledge and the terminology of the certifier [43].

The coherence of any given text is associated with consistency, logic, and textual unity. It also depends on the reader’s willingness and ability to create meaningful relations between facts, events, and evaluations [46]. Coherence is thus a product of the text and the reader’s knowledge, experience, attitudes, expectations, and cultural background [46–48]. Some narratologists may include the narrator’s evaluation of facts and events as one of the main elements of a narrative, without which they regard the narrative as pointless [38].

In our analysis, we investigate the narrative thread and the linguistic markers that constitute the global ‘hanging-togetherness’ of the text: the diagnosis, the story of illness, the symptoms belonging to it, and the patient’s ability to function and capacity to work. We use the term illness when talking about the patient’s symptom complex, as claimants of disability benefits are ill or ill-functioning in the sense of having a subjective experience of being unable to work.

Results
The standard certificate form: dissociating the disease and the patient
We start with a critical review and interpretation of the form text (Table 2). As a starting point, we ask how the form deals with disease and illness without disease. On the form, information about the medical condition is requested in terms of ‘diagnosis and information about the disease’ (Section 2); the form breaks this information down into a ‘main diagnosis’ (Subsection 2.1), an ‘additional diagnosis’ (Subsection 2.2), a ‘disease story with symptoms and treatment’ (Subsection 2.5) and ‘results from clinical examination and relevant tests’ (Subsection 2.6). Thus far, the form reflects a model in which disease – composed of a set of symptoms, clinical and laboratory findings, and adequate treatment – is the main cause of dysfunction. The form reflects the idea that there is both an immediate and predictable relation between disease and dysfunction/working capacity and a medical treatment available that may improve not the patient’s health but their ‘functional ability’ and ‘working capacity’. This is shown in Subsection 5.1 and Section 6 of the form (see Table 2 for full form):

5.1 Describe how functional ability is generally reduced due to disease.

6. Prognosis:
   a) Is the treatment assumed to improve working ability?
   Yes / No
   b) Estimate the duration of the disease/injury
   c) Estimate the duration of the functional disability
   d) Estimate the duration of the reduced working capacity

Sections 5.1 and 6a–d assume that there is a direct relation between disease and ability to function without the patient being viewed as a subject with motivation, beliefs, and a will of their own. Moreover, the form does not ask for the social context (familial, educational) of the claimant, which – according to the National Insurance Act [6] – should be considered a legitimate co-factor of illness. Because an individual’s experience of illness cannot be validated by ‘clinical findings and relevant test results,’ important information about the patient and
other causes of ill-health may be overlooked. In the standard form, NAV adopts a reductionist view and selects, organises, and limits the information it seeks from the GP, using terms of disease exclusively. This is also seen in Section 2.5, the heading of which – ‘history of disease, symptoms, and treatment’ – indicates that there is a narrative to be told. However, the story being asked for is that of the disease, not of the sick person.

**Listing symptoms at the cost of the illness story**

Probably as a reflection of the form’s dissociation between the patient and their disease, there are entire certificates that mention the patient only rarely or not at all and which are almost entirely devoid of narratively organised events and their consequences. Excerpt (a), below, exemplifies how the illness story is replaced by a number of symptoms (all the excerpts are from different certificates and are labelled sequentially with letters a–j). The form questions/sections are numbered according to Table 2. Form text is in bold.

(a) **2.5: History of disease, symptoms and treatment.** Investigated by cardiologist -12 [2012] for a tendency to arrhythmia. Allergies: suggesting wheat flour; gastrointestinal gas. Sensitivity of airways. Afflicted by tinnitus; evaluated [by] the RA [rheumatic arthritis] clinic; Natural functions: a little reflux, ventricular gas, statically: back problems for many years.

Because the list of symptoms/conditions lacks the only element that may connect them – the person to whom they belong – the information comes out fragmentarily, and in the absence of verbs, nothing happens. The only traces of a narrative in (a) are ’-12' and 'for many years,' indicating a time course. As Smith points out [37], any utterance, however small and fragmentary, can have narrative content, and ‘telling about events’ can be indistinguishable from stating that ‘something is’. Are the conditions listed – allergies, tinnitus, back problems etc. – events of the past or are they still causing low functioning and working disability? There is nothing in the text that tells us. Listing a large number of symptoms might be the writer’s attempt to comply with NAV’s notion of disease as the legitimate basis of disability benefits. What the narrative’s ‘worth telling’ is, however, remains unclear. A mere list without specification or evaluation does little to help up comprehend the patient’s problem, and we are left with a pointless story [38]. The reader whom the text addresses will probably have difficulty interpreting the information and taking a decision; indeed, in this particular case, the disability benefits claim was rejected by the NAV.

**Lack of temporal aspects of illness obscures causality**

Because an illness story can be abbreviated, told fragmentarily, or not told at all, as shown in excerpt (a), the sequential events are often omitted. In (b), the undefined time aspect of the claimant’s alcoholism and anxiety disguises a possible problematic relation between the patient’s alcohol consumption and their psychiatric disorder.

(b) **2.5 History of disease, symptoms and treatment.** The patient has a long illness story of alcohol abuse. In addition, she has been struggling with anxiety problems for as many years.

The use of ‘in addition,’ a simple transitional phrase, indicates that there is no causal relation between alcohol abuse and anxiety; however, a competent reader probably cannot help but pose the question: does she have anxiety problems because of alcohol abuse – or is it the other way round? The answer to this question has implications for the treatment of each of the problems. Again, the distinction between what was and what is is blurred, and the illness textually slides into a continuous, non-contextualised state of being where anxiety and alcoholism are depicted as if they were not related.

**Chronicity and the doctor’s chaos narrative**

The medical profession is typically oriented diachronically; taking patient histories is heavily emphasised in the teaching of medical students. Throughout clinical examinations and treatment, the patient’s story – as noted in their medical record – is transformed into medical discourse; but principally it remains a story [49]. The medical certificates in our sample, however, are mainly synchronic; it describes the patient’s present symptoms and complaints as a persistent, static state of affairs. According to the sociologist Arthur Frank, disease starts with an event ‘interrupt[ing] life’ and in some cases slides into an ‘incessant presence with no memorable past and no future worth anticipating’ [50].

Medical certificates of disability typically present illness as a status quo, which is coherent with the purpose of the document. Furthermore, details of the patient’s condition and story are often omitted. We see an example of this in excerpt (c): it starts in the present, describing the illnesses in very general terms.

(c) **2.5 History of disease, symptoms, and treatment.** The patient has a complex health problem with fibromyalgia and extensive muscle pain, [...] asthma and general exhaustion.

The terms ‘complex,’ ‘extensive,’ and ‘general’ seem to replace a thorough depiction of the patient’s illness story which becomes a condition with no pre-history (how was life before the illness started? How and when did the asthma influence her functioning? When – and perhaps why– did she become generally exhausted?).

Arthur Frank [50] has elaborated three empirical categories of illness narratives: first, there is the restitution narrative (the successfully ill – I was healthy, got sick, recovered); second, the quest narrative (the acceptance of illness and how to see the experience as meaningful
for oneself and others); and, finally, the chaos narrative (the persistent disturbance to living caused by illness). According to Frank, the chaos narrative – as opposed to the restitution and quest narratives – is distinct in that it has ‘no sequence’ and ‘no mediation, only immediacy’ [50]. In contrast to stories in which medicine triumphs, Frank asserts, the chaos narrative is a non-plot of ‘never getting better’ that exposes the vulnerable, futile, and impotent sides of the profession. In excerpt (d), below, the writer describes a 59-year-old woman with chronic muscle and joint pain who has no authoritative diagnosis to explain the pain, and, consequently, has been denied disability benefits:

(d) **Diagnosis:** Low back pain L03. Pain in joints IKA L20.

2.5. History of disease, symptoms, and treatment [...] much pain and low function of the shoulder and she was referred to [polyclinic]. There, they found tendinitis. Recommended physiotherapy. The patient has consistent, chronic pain and is treated regularly without improvement of her functioning and there is no curative treatment.

2.6. Current clinical status (specify date). The results of relevant investigations. The patient comes for a talk. [...] Taking new blood tests and glucoses. Supporting talk. Follow-up of results. Try to find discharge summary from the chiropractor. Additionally, she gets a referral to the physiotherapist.

After the introduction, the narrator enters the text as a first-person narrator (although first-person pronoun is omitted), as a GP acting in present time (probably in a consultation). While the activities described here are normal activities in a family practice – the text is most likely cut and pasted from the patient’s record – they are hardly worth telling in a medical certificate. The GP acting in the text, however empathic, does not seem to have a plan: even though therapy has proved to be without effect, the doctor continues to refer the patient to physiotherapy and recommends diverse medical checks not quoted in the excerpt (among them, another MRI). The GP in the text might accept that there is no ‘diagnosis’ and that further treatment and repeated MRIs will not bring more clarity. Instead, this would be a situation that has ‘no mediation, only immediacy’ [50]. An aimless narrative in a certificate may mirror the author’s own ‘chaos’, the GP’s experience of powerlessness when faced with illness without disease.

According to Sarah Nettleton, patients with medically unexplained symptoms (MUS) typically present illness without a clear ‘plot’ or ‘route map’; and, in addition to their ailments, suffer from not having the legitimacy of the ‘sick role’ [51]. Irrespective of the real illness experiences behind the documents – which we cannot know anything about – we find that some narrators take a chaos perspective, turning the patient’s story into what we have chosen to call the *doctor’s chaos narrative*. In the doctor’s chaos narrative, the physician – implicitly or clearly – is ‘stuck’ with the patient, with no way out of the endless cycle of treatment that leads neither to improved health, nor even, perhaps, to welfare benefits for the patient.

**Conflation of voices**

In our material, we find that the voices in the texts are presented in different ways [42]. The narrator may have ‘completeness of information’ about the patient, being an impersonal, authorial, *all-knowing* voice, placed outside the narrative. Then there is *free indirect speech* (no quotation marks or references to the speaker) which may sometimes be inferred as the patient’s voice, given the context of the narrative. Finally, the patient’s voice may be explicit and rendered as *indirect speech* (‘the patient claims/says that...’). The following example is from the certificate of a 50-year-old man with low back pain who has been struggling to convince the NAV official that he is unfit for work

(e) **2.6 Current clinical status (specify date). The results of relevant investigations.** A long talk with the patient [...]. For him, it is not possible to resume work because of his low back pain. Still marked by a long fight with NAV for not being believed.

5.1. Describe how the patient’s functioning is generally reduced due to disease. Cannot sit or stand for long or short periods of time.

5.4. **What is it that the patient cannot do in the present work?** Cannot function in work, unable to withstand either physical work or sedentary work.

In excerpt (e), there are no speaking subjects or references and thus the utterances have no explicit source. The statements in sections 5.1 and 5.4 about the patient’s functionality and working capacity – are they based on the author’s medical observations and knowledge, ‘objectivised’ by the authorial voice to justify disability benefit, or are they the patient’s subjective claims repeated by the narrator in free indirect speech? The conflation of voices erases the distinction between the professional evaluation and the patient’s claims. By using free indirect speech, the narrator has the possibility of not committing to the utterance (which may be inferred as the patient’s own voice) while at the same time making it appear ‘objective’ (inferred as the narrator’s all-knowing voice). The effect in this case is that the narrator can be taken to implicitly promote disability benefits, but without having said it directly.

Only patients can account for their symptoms, and we find that symptoms occupy more space than the diagnosis, which only the doctor is authorised to qualify. Adapting the term *linguistic zone* used by the literary
critic Mikhail Bakhtin [52], we consider symptoms to belong to the patient’s linguistic universe, whereas diagnosis and medical evaluations belong to the doctor’s. In our material, the number of symptoms per certificate ranges from two to fifteen, whereas the number of diagnoses is significantly less, ranging from one to five. By over-emphasising symptoms and complaints, the narrator allows the claimant’s linguistic zone to spread in the text. We find that the corresponding physician’s ‘zone’ within the texts can be displaced or weakened by the narrator’s willingness to leave space for the patient’s linguistic zone, which may perhaps lead the narrator to lose control of the discourse [40].

The countering voice

Sick leave certificates are often issued by GPs in response to patients’ demands [21, 22, 53]. Some studies indicate that conflict or fear of conflict may underlie the decision to issue a certificate [12, 16]. Certifying permanent working disability probably involves many of the same problems, but few studies have looked at how texts made by doctors when evaluating fitness to work reflect uncertainty and possible conflict with the patient. The writer may use linguistic techniques to point to certain connections or to obscure their own opinion. The example below is from a patient applying for permanent disability benefits after years of receiving temporary benefits. The narrator summarises the patient’s functioning and presents his status in a new certificate below (Certificate (f)). We have italicised the connecting words:

(f) Diagnosis: Epicondylitis L93.

2.5 History of symptoms and treatment. Has been doing well in daily life, but not managed to resume work. He has not been working but has tried to occupy himself with small jobs at home. Painkillers taken occasionally — claims to have some effect — but still not ‘healthy’ enough to resume work and wants a prolongation of his disability pension. 8. Optional information. ‘He has less pain at rest but still has pain related to physical efforts.

With the exception of ‘claims to have’ in excerpt (f), which is the patient’s indirect speech, the text contains free indirect speech; this speech is probably the patient’s, as it refers to events within the private sphere to which the narrator has no direct access and to the patient’s subjective experience of pain. ‘But’ is a concessive conjunction, which is typical of an argumentative text type; in excerpt (f) it is used systematically to counter statements [54]. We find segments of two opposing narratives, both of which stem from the patient: one referring to his private life (with some achievements) and the other repeatedly to ‘work’ (no achievements). It is not evident why the patient is still unable to work, and the organisation of the text with ‘but’ suggests doubts or disbelief about the patient’s unfitness for work.

Bakhtin [55] points out that the essential quality of an utterance is its addressiveness: it is always directed at somebody. In the case of the medical certificates, not only is there the formal receiver of the document, but there are also super-addressees – potential readers who are not directly addressed but whom the writer nevertheless has in mind [55]. In excerpt (f), the writer seems to have the patient in mind as a super-addressee; he or she seems to question the patient’s eligibility, but only indirectly, using free indirect style. Using free indirect style here has the double effect of seeming close to the patient while at the same time creating a professional distance [40]. Moreover, putting ‘healthy’ in quotation marks creates a latent irony that must be inferred by the reader, but which may weaken the claimant’s case. Contrary to the narrator in excerpt (e), the narrator in excerpt (f) seems to have doubts about the patient’s claims; none of the narrators, however, expresses their position directly.

Clarity and ambiguity

Clinical reports usually describe rather than explain. They address readers who have the same professional knowledge as the writer and who are able to infer connections, even in a brief and fragmentary text. In a medical certificate, however, explicit explanation is needed to make the relations between statements clear, as these relations may justify granting benefits. Connective words create meaningful relations between clauses: causal (because, so), adverse (but), temporal (then), or additive (and) words indicate that the text type is explicative, argumentative, narrative, or descriptive, respectively [54, 56]. A document may present with all text types depending on whether the writer’s intention is to explain phenomena, describe facts, tell a story or evaluate/argue. A text may have formal markers showing connections between events, or it may have no markers and still clearly display such connections, as shown in the text below:

(g) 2.5. History of disease, symptoms, and treatment. She was admitted to hospital. She had back pain, had several falls and paresis. CT showed spinal stenosis.

Even though this small text has no markers, we interpret it as recounting a series of events, a narrative. It is also implicitly causative: the patient was brought to hospital because of her symptoms which were due to spinal stenosis. What makes us see this text as coherent, and not as just disconnected clauses, is the co-occurrence of items (back pain — falls — paresis — spinal stenosis), which is a general tendency in texts, known as collocation. Accordingly, a competent lay reader will most probably grasp the causal meaning of this text even in the absence of causal conjunctions. In contrast, the
additive text type in excerpt (h), below, is similar to that of (g), but unlike (g), (h) creates spurious connections of causality:

(h) 2.5. Illness story, symptoms, treatment. Pain in the neck, numbness of hands, especially left arm and hand. MRI of the cervical spine shows a minor prolapse at the spinal level C3-C4. 2.6: Current clinical status (specify date). The results of relevant investigations:

Contrary to excerpt (g), excerpt (h) uses association in a way that can be considered fraudulent. The immediate position of the sentences in relation to one another suggests that the numbness of the left hand is caused by the prolapse at the C3-C4 level of the neck as shown by an MRI. An authorised reader will know that a prolapse at the C3-C4 level of the cervical spine cannot cause general numbness of the hand and therefore will not be surprised that the personal examination of the patient is negative. However, the narrative technique used here, which draws on the reader’s associative ability, is exposed: the text implicitly suggests connections that are faulty, even though they seem ‘reasonable on the surface’ [40]. The writer, however, can only be blamed for creating ambiguity, not for deliberately giving faulty information.

Assessing functionality and working capacity

A lack of information necessary to understand chains of reasoning may create the appearance of incoherence, or even of bias, for the reader. This can create problems in interpretation, especially when there is a request for causal relations between the elements. In excerpt (i), below, the writer neither describes their personal examination of the patient nor provides any other medical results of investigations:

(i) Diagnosis: Spondylolisthesis L4. GERD (gastro-oesophageal-reflux-syndrome) D84.

2.6 Current clinical status (specify date). The results of relevant investigations. Physical, medical problems causing pain. The patient cannot work. Working is out of the question for the patient. Permanent disease/syndrome with daily symptoms.

In this certificate, detailed medical descriptions explaining how or to what degree the spinal defect and reflux restrict the patient’s bodily and practical daily functions, and how these conditions might explain his reduced working capacity, are replaced by generalisations. In some cases, as in (i), the disease-related diagnosis seems insufficient to explain a total and absolute loss of working ability and appears to serve instead as a Trojan horse of clinical ‘dignity’, or as a legitimate basis of disability benefits. GPs have reported having difficulty describing the impact of subjective health problems on functioning and work ability; they prefer selecting what is most concrete, organ-related, and objectively verifiable [28]. In (i), as in other certificates in our sample, there are various organ-related diagnoses, coded with 70–99 in the ICPC-2 system (International Classification of Primary Care, 2nd edition); however, none of them are accompanied by evaluations of patient functioning that might explain why the patient is unable to work. This might be because no matter the diagnosis, which itself has little to do with the patient’s functional abilities, it is difficult for the doctor to assess the patient’s functioning.

Breaking of the norm

The fact that ‘disease’ is a non-specific and relative concept, and that NAV might also consider illness as a legitimate basis for benefits – even in the absence of biomedical indicators – leaves a fair amount of room for negotiating eligibility for welfare benefits [4]. Moreover, NAV policy gives more weight to an individual’s degree of impaired functioning than to the medical diagnosis itself [57]. Therefore, deliberately advocating disability pension without any indications of verified disease, illness, or reduced function threatens the narrator’s reliability all the more. In excerpt (j), below, the writer explicitly disproves reduced functioning, yet still suggests that benefits should be considered:

(j) Diagnosis: Myalgia L18.

2.6. Current clinical status (specify date). The results of relevant investigations. One has, for more than ten years, not managed to get the patient back to work, and therefore, disability pension should be considered.

5.0 Describe how the functioning is generally reduced because of disease. The patient claims to have myalgia, but there are no somatically reduced functional abilities.

Here, instead of providing the information requested in Section 2.6, the writer immediately introduces the realities of a failed rehabilitation. In Section 5.0, the writer denies that the patient’s functioning is impaired at all. Proposing disability benefits for someone who is not really eligible puts the narrator in conflict with the basic norms of the text – and hence with the implied author (the GP), whose expert standard is expected to comply with the norms displayed in the form text. The writer’s pragmatic suggestion may signify a professional resignation to a long process in which the medical problem is perhaps only of minor importance.

Discussion

In this paper, we have carried out a close, critical reading of a selection of medical certificates issued in Norway. Whereas other studies show that GPs experience certifying as challenging [8, 17], we have aimed at showing how GPs actually select and mediate information about their patients’ health, functioning, and work capacity. Our text
Certifying GPs find the standard form problematic and partly unfit for describing the common sicknesses of our time [28, 58]. We suggest that the form is, to some extent, outdated in relation to the sicknesses and patient-oriented policy of our time and can thus be misleading as to what can in fact be verified by a physician as a cause of working disability. Certifiers seem to struggle to adapt to the form or, more precisely, to the form’s implicit assumptions that any illness can be narrated chronologically and that ‘treatment’ is always needed to improve working ability. Subjective illness and chronic pain that cannot be explained by recognised biomedical criteria, and for which there is no effective treatment, can create an extra burden for both the patient [51] and the treating GP acting as a certifier [28]. This sometimes results in what we have called the doctor’s chaos narrative, reflecting the doctor’s impotence when ‘stuck’ with the patient in a never-ending search for objective findings. In addition, our analysis identifies elements of textual ‘chaos’ throughout the sample texts: disconnected lists of symptoms, missing time aspects, ambiguities and conflation of voices indicating a lack of professional clarity.

The medical certificate is a particular genre of text, hovering on the border of law and medicine. Even though being a certifier engages the GP as part of ‘an apparatus of social justice’ [7], they show little consciousness of the ethics of the medical certificate as a juridical document. According to our analysis, GPs’ ‘strategic writing’ [20] probably entails a variety of chosen linguistic techniques, some of which are subtle. GPs might use subtle writing in the interest of patient advocacy; however, they might also use it to express disagreement with their patients [12]. When it comes to avoiding vagueness and ambiguities, this is not merely a question of textual skills. Rather, we think that such textual failures mirror physicians’ real problems with how to assess, verify and report patients’ functioning and working ability. In addition, there are no specific criteria for assessing impaired functionality – guidelines are few and not mandatory and the medical information can be vague or deficient [59]. Finally, writing a deficient, inaccurate or biased certificate usually carries no negative consequences for the GP.

The mastery of textual skills in a professional genre is not self-evident and should be taught specifically. Physicians in Norway receive no systematic instruction in either medical school or subsequent training on how to produce high quality text in medical certificates. It is probable that medical certificates depend as much on the interest, writing skills, and capacity of the individual certifier as on his/her attitudes and personal values [23]. We suggest that learning in how to write medical certificates (and medical texts in general, which can all be used as juridical documentation) should be integrated as part of the professional curriculum taught in in medical schools. We assume that high quality medical certification strengthens legal protections for the claimant/the patient and reduces arbitrariness in the assessment of disability. Furthermore, we have reason to believe that providing medical certificates with sufficient and necessary information that are accurate, verifiable, and coherent is also economical. Such certificates may facilitate NAV’s work with disability benefit applications, reduce the use of expensive, extra resources and shorten the processing time for disability benefits cases. In addition, the expert’s impartiality and explicitness about his/her uncertainty and limited insight will probably reinforce the legitimacy and reliability of the document. Although a range of other measures is necessary to ensure that benefits are allocated fairly, we believe that GPs taking their role as certifying experts seriously according to the criteria mentioned here will contribute to a fairer evaluation of whether claimants are in fact eligible or not for disability benefits.

On the basis of our findings, it is reasonable to revise the role of GPs as certifiers of fitness for work in Norway. We suggest two possible measures: first, the GPs’ role should be shared with other actors involved in evaluating patients’ treatment and functioning, and the questions posed to the GPs from the NAV should be revised to fit better with the causes of reduced work ability. Second, physicians, medical students, and other health providers involved in certifying health problems should undergo specific instruction in how to write certificates, preferably taught by humanities professors. These measures may improve the quality of certifying documents, and thereby contribute to increasing efficiency and justice in the distribution of public goods.

Conclusions
Certifying GPs frequently failed to provide clear, sufficient and relevant factual information and coherent
medical evaluations to justify the patient’s claims of disability pension. The certificates may not function as reliable sources for making decisions regarding social benefits.

Whereas a deficient certificate has no negative consequences for the certifying GP, it may complicate NAV’s treatment of the case, delay the decision and increase costs by the use of (usually unnecessary) specialists. In addition, insufficient, unclear and biased documentation may lead to wrong or unfair decisions.

Physicians in Norway receive no systematic training in professional writing. We believe that professional writing skills should be validated as an important part of medical practice and should be integrated in medical schools and in further education as a discipline in its own right, preferably involving humanities professors.

Remarks on method

Compared to our primary selection, we obtained consent to participate from more persons with musculoskeletal diagnosis and from fewer persons with psychiatric diagnosis. However, all main diagnostic categories are present in our material, and we do not think the imbalance in the diagnoses is of importance for the results.

Abbreviations

GP: General practitioner; NAV: Norwegian Administration of Labour and Welfare

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Availability of data and materials

The data that support the findings of this study were used under license for the current study and so are not publicly available. Data materials in the form of medical certificates are, however, available from the corresponding author (paper documents or scanned data files) upon reasonable request and with permission of the Directorate of National Labour and Welfare and The Norwegian Social Science Data Services (NSD)/Data Protection Official for Research.

Authors’ contributions

All of the authors conceived of the study and participated in elaborating the consent letter, the study design, methods, and themes. GA carried out the data collection and the primary textual analysis and wrote the first draft. BN, AKL, EE and GA have participated in performing and refining the textual analysis and all authors have contributed to the revisions and approved the final version.

Competing interests

Second author Bård Natvig, professor of general practice, also has income as a part-time medical consultant in insurance medicine. The other authors do not report any conflicting interests.

Consent for publication

The authors made a consent letter which also provided information about our project and its implications to the participants. The consent letter was approved by the Norwegian Social Science Data Services (NSD)/Data Protection Official for Research (ref. 28836/3/KS) and sent to all patients whom the medical certificates concerned. Only copies of certificates of patients who, by signing and returning the consent letter had accepted participation (by permitting our access to their medical certificates) and publishing, were included.

Ethics approval and consent to participate

Study approval was granted from the Norwegian Social Science Data Services (NSD)/Data Protection Official for Research (ref. 28836/3/KS). Our access to the confidential medical certificates was approved by the Directorate of Labour and Welfare and the Council of Secrecy and Research in the Ministry of Justice and Public Security (ref. 1/2325).

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Author details

1Department of General Practice, University of Oslo, Faculty of Medicine, Institute of Health and Society, Postboks 1130, Blindern 0318, OSLO, Norway. 2Department of Health Science, University of Oslo, Faculty of Medicine, Institute of Health and Society, Postboks 1089, Blindern 0318, OSLO, Norway. 3Department of Community Medicine and Global Health, University of Oslo, Faculty of Medicine; Institute of Health and Society, Postboks 1130, Blindern 0318, OSLO, Norway.

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