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BMJ Open Is clinician refusal to treat an emerging problem in injury compensation systems?

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ABSTRACT

Objective: The reasons that doctors may refuse or be reluctant to treat have not been widely explored in the medical literature. To understand the ethical implications of reluctance to treat there is a need to recognise the constraints of doctors working in complex systems and to consider how these constraints may influence reluctance. The aim of this paper is to illustrate these constraints using the case of compensable injury in the Australian context.

Design: Between September and December 2012, a qualitative investigation involving face-to-face semistructured interviews examined the knowledge, attitudes and practices of general practitioners (GPs) facilitating return to work in people with compensable injuries.

Setting: Compensable injury management in general practice in Melbourne, Australia.

Participants: 25 GPs who were treating, or had treated a patient with compensable injury.

Results: The practice of clinicians refusing treatment was described by all participants. While most GPs reported refusal to treat among their colleagues in primary and specialist care, many participants also described their own reluctance to treat people with compensable injuries. Reasons offered included time and financial burdens, in addition to the clinical complexities involved in compensable injury management.

Conclusions: In the case of compensable injury management, reluctance and refusal to treat is likely to have a domino effect by increasing the time and financial burden of clinically complex patients on the remaining clinicians. This may present a significant challenge to an effective, sustainable compensation system. Urgent research is needed to understand the extent and implications of reluctance and refusal to treat and to identify strategies to engage clinicians in treating people with compensable injuries.

INTRODUCTION

Most doctors enter the medical profession in order to serve the needs of people who are unwell. This is grounded in the ethical principle of beneficence—acting in the interests of others in need.¹ While most doctors embrace their ‘duty of care’ to people in need, they may not consider refusal to treat,

Strengths and limitations of this study

- This is the first study to describe the constraints of doctors working in complex systems that may influence reluctance to treat.
- Interviews with 25 general practitioners (GPs) provide novel insight into how reluctance to treat may compromise the sustainability of a complex system such as compensable injury management.
- GPs were recruited through purposive sampling in Melbourne, Victoria; it is unknown how representative their experiences are of GPs in other regions of Australia.
- In opening a new avenue of inquiry, our study highlights the need for future, larger scale research to explore the extent and impact of reluctance and refusal to treat, and how to effectively address it, so that patients with compensable injuries can access the care they need.

or declining to accept the duty to care, as ‘unethical’.²

Indeed doctors are under no legal obligation to care for all people who require their services and are free to choose who they treat and who they do not. However, this freedom is not limitless and there are significant debates in bioethics as to how much freedom doctors should have.³ The ethical implications of refusing to treat may depend on the reason for doing so.² The two most common reasons reported in the literature are first, conscientious objection, that is, the refusal to provide care that is necessary but which the doctor believes is morally wrong (eg, abortion and contraception).^{4–7} The second reason for refusing to treat may be to avoid subjecting patients to invasive or burdensome treatments of limited efficacy (eg, undertaking lumbar spine fusion or disc replacement surgery as a method of pain relief).^{8,9}

With the exception of these two objections, other reasons that doctors may refuse to treat and/or be reluctant to treat have not been widely explored in the medical literature. To understand the ethical implications of refusing to treat and/or being reluctant to treat,

there is a need to recognise the constraints of doctors working in complex systems and to consider how these constraints may influence refusal to treat. The aim of this paper is to illustrate these constraints using the case of compensable injury in the Australian context. As compensation systems differ between countries, with differences in the role of the health professional in occupational health and different recovery pathways,^{10–13} a description of the Australian context is provided below.

Context of compensable injury management in Australia

The cost of compensable injury in Australia has been estimated at A\$60.6 billion, or 4.8% of gross domestic product.¹⁴ The average cost per case of workplace injury is \$A99 100 and of this, \$A73 300 is paid for by the injured worker themselves.¹⁴ The majority of costs are therefore borne by the injured person; about one-third of injured workers receive workers' compensation and about a quarter receive support entitlements from their employer.¹⁵ The most common workplace injuries in Australia are musculoskeletal injuries, followed by an increasing prevalence of work-related mental health issues.¹⁶

This study was conducted in the state of Victoria, where legislation states that all compensable injury claims must be lodged at the two statutory authorities: WorkSafe Victoria for work-related injuries, and the Transport Accident Commission for vehicle-related injuries. To make a claim, an injury claim form and initial certificate of capacity completed by a medical practitioner must be filed. Once a claim has been assessed and accepted, compensation payments may start for lost income and costs associated with medical services.

While jurisdictional variation exists throughout other states in Australia, general practitioners (GPs) are almost always the first point of contact with the healthcare system in the case of a compensable work injury, and most often the first point of contact in compensable transport injury, thus making them the main gatekeepers to compensable benefit entitlements.¹⁷ Through sickness certification, Australian GPs make recommendations that can influence the duration of time away from work taken by injured workers, and this influences the costs of work absence that are borne by the compensation systems. The GP plays a key role in diagnosis, providing advice, and facilitating the treatments required for return to work (RTW).¹⁷ In assessing fitness for work, the GP most commonly relies on the patients' own assessment of their functional capacity in relation to the demands of the workplace,¹⁸ although safe, appropriate and timely RTW is meant to be jointly coordinated by the GP, the injured person, the injured person's compensation agent and employer.

In the Australian setting, GP clinics operate as private businesses (unlike in the UK's National Health Service), and GPs are free to choose how they run their business.¹⁹ From a business point-of-view, GPs can decline treating patients with compensable injuries on the basis

that they do not have an available appointment or that by treating a compensable injury patient, the care of existing patients will be compromised. The only instance in which a GP cannot refuse treatment is in the case of a life-threatening emergency²⁰ and legislation prevents GPs from refusing treatment on the basis of a patients' race, religion, gender, employment activity or political beliefs.²¹ Thus, we were surprised to hear reports of doctors' refusing to treat and directly uncover cases of GPs being reluctant to treat people with compensable injuries in our wider qualitative investigation examining the role of the GP in RTW (the GP-RTW study).

METHODS

The GP-RTW study sought to explore the knowledge, attitudes and practices of GPs, injured workers, employers, and compensation agents about the role of the GP in facilitating RTW in people with compensable injuries. The study comprised semistructured face-to-face interviews with 25 GPs, 17 injured workers, 25 employers and 26 compensation agents (n=93 participants). Data were collected between September and December 2012. Descriptions of the processes undertaken to recruit GPs, injured workers, employers and compensation agents has been previously published²¹ as have study findings related to mental health claims management,²¹ GP certification practices¹⁸ and employer perspectives on the GP's role in RTW.²² This paper seeks to understand the reasons for reluctance to treat from the GP perspective, a phenomenon that emerged during interviews with all stakeholders. Since our focus is only on GPs in this paper, here we only document recruitment procedures for this cohort.

GPs were recruited from a database comprising over 500 GPs practising in Melbourne, Victoria, who had agreed to be contacted for research activities. Fax invitations were sent to practices and interested GPs contacted the researchers. To be included in the study, GPs had to currently or have in the past 12 months treated persons with an injury compensation claim. All GPs who contacted the researchers in response to the invitation, who met the inclusion criteria, and gave informed consent, were then purposively sampled on the basis of location of practice, gender, age and years of experience as a practising GP. Participants were recruited until sufficient data had been collected to reach a level of data saturation regarding the knowledge, attitudes and practices of GPs in Melbourne, Australia, regarding compensable injury management.

Semistructured interviews lasting between 45 and 60 min were completed by two female research assistants with training and experience in conducting qualitative interviews. Face-to-face interviews took place in a private consulting room at the GP's practice. The interviewers were previously unknown to the participants. Topics covered included opinions of what the GP's role should be in RTW, the actual role GPs played in RTW, GP

experiences in navigating health and compensation systems, and the barriers and enablers of RTW. Field notes were taken after the interviews and all interviews were audio-recorded. GPs were reimbursed \$200 for their lost consultation time, a sum which is in line with the hourly rate of GPs in Australia²³ and consistent with previous studies involving the recruitment of Australian GPs.²⁴

A detailed description of the data analysis process for this study has been published.²¹ Recorded interviews were transcribed verbatim. Transcripts were checked and cleaned prior to data analysis. Thematic analysis was employed.²⁵ Initial coding schemes were developed by four co-authors using inductive methods. Transcripts were coded by two separate authors and cross-checked to verify interpretation. Any differences were resolved by consensus discussion. The final interpretations were confirmed and agreed on in group discussion. Coded transcripts were entered into NVivo V.10 for further analysis.

Data coded as 'reluctance to treat' in NVivo V.10 were further analysed by two co-authors (BB and SB) using thematic coding. We identified four main codes: financial, time, clinical and emotional reasons for reluctance to treat that we grouped into two main themes illustrating the key constraints of compensable injury management that could influence GP reluctance to treat: administrative reasons for reluctance to treat, and clinical reasons for reluctance to treat.

This study followed the consolidated criteria for reporting qualitative research (COREQ) guidelines.

Sample

Participants included 25 GPs (18 male (m)/7 female (f); mean age=52 years (yo)), with an average of 24 years of experience (ye) in their current job role. GPs came from locations across Melbourne (South (13), North (1), East (6), West (3), Central (2); see table 1).

RESULTS

Almost all GPs in the study noted that their GP colleagues and medical specialists that they referred patients to had at some point refused to treat compensable injury patients. A few GPs reported that they also refused treatment to patients with a compensable injury who presented to their clinic for the first time. However, as the inclusion criteria required GPs to have treated or be treating patients with compensable injuries at the time of the study, most GPs commented on their reluctance, rather than refusal, to treat patients with compensable injury. The administrative and clinical reasons for refusal or reluctance to treat we identified are described hereafter.

Administrative reasons for refusal to treat: 'It's more stress than what you get paid for'

For GPs, the costs involved in the management of a compensable injury case were perceived as high. Time costs

Table 1 Participant characteristics

Code	Gender	Age	Years of experience	Location of practice
01	Male	62	40	South
02	Male	55	27	South
03	Male	53	35	South
04	Male	58	32	East
05	Male	36	7	South
06	Male	52	30	South
07	Male	33	5	South
08	Female	53	25	South
09	Male	65	40	West
10	Male	66	38	Central
11	Male	64	38	South
12	Male	59	30	East
13	Male	67	41	North
14	Male	53	27	South
15	Male	54	25	West
16	Female	51	22	South
17	Male	31	4	East
18	Male	60	30	East
19	Female	37	13	South
20	Female	47	21	Central
21	Female	39	7	East
22	Female	49	20	South
23	Female	49	6	East
24	Male	49	17	West
25	Male	50	25	South

to GPs were highlighted by all stakeholders. GPs emphasised the time spent on non-clinical tasks such as communicating with other stakeholders, writing reports to compensation bodies and fulfilling legal obligations:

Often you have to provide more documentation, notes... the ongoing battles, it all delays the smooth running of things. (GP#6, m, 52yo, 30ye)

For time-poor GPs, time spent on these non-clinical tasks was perceived as excessive. They described how non-clinical tasks took them away from other patients. To reduce the impact on 'clinical time', some GPs opted to complete non-clinical tasks related to workers' compensation after hours and on the weekend. But this built up resentment and contributed to negative attitudes towards compensable injury cases:

We are all over-worked and over-tired. I've had times where I've been here two hours after I should have left, doing workers compensation forms. That just builds resentment up and that's not a very good way to be dealing with a patient. The resentment is not about the patient, it is actually about the system but it is hard for that to not get involved in the consultation. (GP#20, f, 47yo, 21ye)

Reluctance to treat by other specialists also influenced the GP's own experiences of treating people with compensable injuries. GPs observed that an increasing

number of specialists were refusing to treat patients with compensable injuries. They reported that it often took several attempts to find a specialist who would accept a compensable injury referral. Time spent on the phone was unpaid time for the GP:

It's a time thing. It's me sitting there ringing around looking for someone who is willing to see this patient. It comes back to that—the compensation cases take up a lot of your time. And it's unpaid time. (GP#19, f, 37yo, 13ye)

The financial costs involved with managing people with compensable injuries were frequently raised by the GPs. Almost all GPs reported delayed payments for their services because of doubts over the legitimacy of the claim by compensation bodies and employers as well as administrative delays from compensation agencies. As a result, some GPs perceived that treating patients with compensable injuries was 'not worth the hassle':

There are issues with insurance companies not paying them, it's not worth it. Doctors don't need all that hassle. (GP#11, m, 64yo, 38ye)

Several GPs got around this by only accepting patients with compensable injuries who agreed to pay privately for the GP services:

A lot of my colleagues will not see patients under the workers compensation system, they'll see them privately. The patient pays as if it's a normal consultation. Then the patient has to claim that back from the insurer or employer. A lot of patients don't like that, so they won't go to their doctor. Well the doctor doesn't mind. (GP#11, m, 64yo, 38ye).

Clinical reasons for refusal to treat: the 'difficult' cases

GPs also described the complexities associated with compensable injury management as a reason to refuse treatment. These complexities included a lack of 'visible' symptoms, the beliefs and expectations of the patient, poor clinical outcomes and strained employer–employee relations.

Compensable injury cases were perceived by GPs as 'difficult'. This GP described how his colleagues 'dumped the difficult cases' on him, leaving the 'easy non-compensable-injury-patients' for themselves:

The other GPs at the practice are dumping the difficult cases on me...I think: "Hang on, I'm not a dumping ground for you guys. Don't keep the difficult cases for me." I think it's pretty unfair. They just want to take the easy patients and give me all the hard ones. (GP#5, m, 36yo, 7ye)

The complexities involved with a compensable injury case presented a clinical challenge for the GPs. A common difficulty appeared to be in determining whether the claim was honest or whether the patient

was motivated by 'secondary gains' (ie, social or financial rewards associated with disability). Given that the GPs had a gatekeeper role to entry into the compensation system, the onus was on them to ensure that the claim was valid and justifiable. For many, this role was unwelcomed and cited as a reason for reluctance to treat:

We're going to have doubts whether this patient is honest or not. We'll have to write reports about this person. If I could avoid doing workers compensation I would. (GP#9, m, 65yo, 40ye)

A lot of orthopaedic surgeons will not see workers compensation cases because they don't want to get involved with the issues of secondary gain. (GP#4, m, 58yo, 32ye)

An important way of determining whether a claim was valid and justifiable was having an in-depth understanding of the patients' history. This was difficult to obtain in compensable injury cases that had been 'inherited' from other GPs mid-claim or when the person was not an existing patient at the clinic:

It is not often that I'd take on a patient if the compensation case is my first contact with a patient. For a long time my books have been closed...but the people whom you already know very well, you sort of have some idea of their background. (GP#25, m, 50yo, 25ye)

Difficulties establishing trust also appeared to be a factor influencing GPs reluctance to treat some new patients presenting with compensable injuries. In cases where patients presented with unhelpful beliefs and treatment expectations that are recognised as barriers to RTW, such as the belief that activities should be avoided when in pain, GPs described the importance of having the patient's trust in order to challenge these beliefs and encourage compliance with treatment recommendations:

It's hard when you've never met the person before because why should they believe me? They don't know me. My patients have known me for years, they trust me, that's why they've come along. They'll believe what I tell them. (GP#12, m, 59 yo, 30ye)

Non-compliance with treatment recommendations was cited as a reason for reluctance to treat:

If you don't want to follow my recommendations, then I don't have to be your doctor and I won't be your doctor for compensation. (GP#4, m, 58yo, 32ye)

GPs commonly perceived that compensable injury patients were likely to have poor clinical outcomes. This GP who reported a reluctance to treat, described how he lacked the tools, and felt helpless to effectively treat patients with compensable persistent musculoskeletal pain:

You got these people with this chronic musculoskeletal pain and you tried everything and nothing's working but they are in genuine pain. What do you do? There's just nothing. (GP#5, m, 36yo, 7ye)

In some cases, GPs perceived it likely that a claim would be contested by the patients' employer. This particularly appeared to be the case for work-related mental health injuries or musculoskeletal injuries that often lacked pathoanatomical evidence such as low back pain. A contested claim could exacerbate the patients' mental distress, delay access to treatment and delay payment to the GPs. For such cases, several GPs said they were reluctant to initiate a workers compensation claim and advised patients to think carefully about whether they wanted to proceed with a claim:

When people come and they perceive they're being bullied at work and ask me to put in a compensation claim, I say, "Well just be careful because...you have every right to, if you feel that you've been hard done by, you've been bullied at work and treated unfairly. The facility is there. But it's going to be a dog fight. Because it's going to be a relationship problem and unless the employer is 100% behind you, they'll challenge it. (GP#12, m, 59 yo, 30ye)

Finally for a couple of GPs, their reluctance to treat compensable injury cases was a matter of clinical preference. This GP described how he did not 'like' managing patients with compensable injuries but felt he had a clinical obligation to do so:

I don't like doing pap smears but you've got to do it. I don't like obstetrics but you've got to do it. It's just part of your work, you know. If you didn't want to do everything, what's the point of working there? (GP#5, m, 36yo, 7ye)

The time and financial costs combined with the clinical challenges of managing patients with compensable injuries impacted on the emotional well-being of some GPs. These GPs who reported a reluctance to treat, described compensable injury cases as exhausting and stressful:

It's time consuming, it's exhausting, the patients are exhausting. (GP#19, f, 37yo, 13ye)

It is not really just medicine. There is so much more to it. And GPs feel it's more stress than what you get paid for unfortunately. (GP#17, m, 31yo, 4ye)

It is interesting to note that the emotional impact of compensable injury management was highlighted by two of the younger GPs in this sample. The role that years of experience as a GP may play in compensable injury management was also raised by this participant with 30 years of experience who suggested that it may be particularly challenging for younger GPs who do not have

confidence in their clinical skills or the industry contacts to help them navigate the compensation system:

Confidence comes with experience. A younger GP coming out of med school may find it a little bit intimidating. I think knowledge of the local industries and building up a network also helps. (GP#12, m, 57 yo, 30ye).

DISCUSSION

In Australia, as elsewhere in the world, GPs are bound to uphold the core values of medical ethics. These include beneficence—that a clinician should act in the best interest of the patient—as well as non-maleficence: that a clinician must above all, do no harm.¹ GPs, like other doctors, also have professional ethical and social responsibilities, which mandate that they treat compensable injury patients irrespective of the extra burden this places on them as well as advocate for reform of the current compensation system. While many GPs do undertake these tasks, including advocacy,^{18 26} change is incremental and slow. Meanwhile, it appears that when it comes to patients with compensable injuries in Australia, the moral obligation of GPs 'to provide care and do no harm' is challenged by current practice constraints, including the financial, time, clinical and emotional reasons for reluctance to treat.

The status quo of refusal to treat is that patients are provided a referral to receive care elsewhere.^{4 20} In this way, arguably, the ethical implications of refusing treatment are limited as the GP is still fulfilling a 'duty of care', and is satisfied in the knowledge that the patient will receive the care that they need. However, the reasons for reluctance to treat identified in this study suggest that in the case of compensable injury management, reluctance to treat is likely to have a domino effect ultimately resulting in more doctors refusing treatment. The more compensable injury patients that a GP has at any one time, the more likely they are to bear the time and financial costs and experience the clinical challenges that can make them reluctant to treat and eventually drive them to refuse treatment. Their refusal of treatment will increase the burden on the remaining GPs, who in turn, may also become reluctant to treat and eventually refuse to treat. In this way, it may become increasingly difficult for GPs to refer patients to receive care elsewhere, and for patients to access the care they need. Strong evidence shows that the timely treatment of people with compensable injuries is important to facilitate recovery and RTW.²⁷ As GPs play a key role in the facilitation of RTW, their reluctance to treat may delay RTW with significant impacts on the patients' physical, psychosocial and financial well-being.²⁸ This finding, also shown in Kilgour *et al's*²⁹ systematic review, underscores that when health providers' frustrations with the compensation system biases treatment against injured workers, clinical encounters may become more harmful than therapeutic. Equally, GP reluctance to

treat may also present a significant challenge to an effective, sustainable compensation system as even finding an entry point into the health system becomes increasingly difficult.

Certainly GPs cannot be expected to provide care to all patients that need it and to bear the costs associated with doing so. However, they are arguably obligated to consider the potential ethical implications of their reluctance to treat and to participate in the debate to ensure that all patients receive care.² In the case of compensable injury management, GP reluctance to treat is a complex issue informed by several systematic factors. Ultimately, to ensure an effective and sustainable compensation system, it may be necessary to reduce the time and financial burden to GPs. Such reforms have been attempted in Sweden, which undertook administrative reforms to regulate compensation certification and established a 'rehabilitation chain' guaranteeing patients access to coordinated RTW rehabilitation. However, these reforms have not shifted the negative attitudes of Swedish GPs towards compensable injury management.³⁰ Swedish GPs continue to consider compensable injury management as 'burdensome' due in large part to the clinical complexities associated with such cases.³⁰ It is likely that in addition to system-level changes, GPs may need more training to better equip them to manage the complex biopsychosocial factors involved in a compensable injury case.^{12 18 21}

Design limitations

Through purposive sampling, we achieved a sample of GPs from different geographical locations but an unequal representation of gender and age with most GPs being male, predominantly in their 50s and highly experienced. However, this demographic breakdown is not unusual as there are more male than female GPs in Victoria, the majority are in their 50s, and because of their age, have been in practising GPs for several years, often decades.³¹ Nevertheless, it is unclear how GP's perspectives of reluctance to treat captured in this study may differ from that of younger GPs with less experience. To address limitations of the present work, future research should include the experiences of GPs from other states alongside the views of specialists and allied health professionals. Including these diverse views will help to illuminate how widespread reluctance to treat is and in what clinical contexts it emerges. Further, as the aim of this qualitative study at the outset of data collection was not to explore the concept of reluctance to treat to data saturation, we can only describe this new line of enquiry, but are unable to comment on the degree to which we captured the diversity of views on reluctance to treat.

Study implications

To the best of our knowledge, no other study has documented GP reluctance to treat in the compensable injury sector. While some studies have mentioned a

reluctance of GPs to act as 'gatekeepers' in sickness certification,³² ours is the first to explore this phenomenon, and explain why. In opening a new avenue of inquiry, we have only touched on the ethical implications of reluctance to treat in an Australian setting. Indeed, our study raises more questions than it answers: How widespread is reluctance to treat? Is reluctance to treat more common among some clinician groups than others? What are the ethical implications if a clinician refuses to treat? How do GPs negotiate the impact of reluctance to treat on the doctor-patient relationship and on business interests? What incentives (and disincentives) should be put in place to mitigate reluctance to treat? Given the paucity of literature on this topic, further research is needed to understand the extent and the implications of reluctance to treat, and to identify strategies to engage clinicians in treating people with compensable injuries. Only then can we seek to achieve optimal RTW practices. To address the ethical implications of reluctance to treat in compensable injury management, we must start by addressing practical and systemic factors influencing this practice.

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REFERENCES

1. Gillon R. Medical ethics: four principles plus attention to scope. *BMJ* 1994;309:184-8.
2. Hood V. Can a physician refuse to help a patient? American perspective. *Pol Arch Med Wewn* 2008;118:368-71.

3. McLeod C, Downie J. Let conscience be their guide? Conscientious refusals in health care. *Bioethics* 2014;28:ii–v.
4. Kantymir L, McLeod C. Justification for conscience exemptions in health care. *Bioethics* 2014;28:16–23.
5. Card RF. Conscientious objection and emergency contraception. *Am J Bioeth* 2007;7:8–14.
6. Shaw J, Downie J. Welcome to the wild, wild north: conscientious objection policies governing Canada's medical, nursing, pharmacy, and dental professions. *Bioethics* 2014;28:33–46.
7. Kolars A. Am I my profession's keeper? *Bioethics* 2014;28:1–7.
8. Harris IA, Dantanarayana N, Naylor JM. Spine surgery outcomes in a workers' compensation cohort. *ANZ J Surg* 2012;82:625–9.
9. Deyo R. Diagnostic evaluation of LBP. Reaching a specific diagnosis is often impossible. *Arch Intern Med* 2002;162:1444–7.
10. Franche R, Camide N, Hogg-Johnson S, *et al*. Course, diagnosis and treatment of depressive symptomatology in workers following a workplace injury: a prospective cohort study. *Can J Psychiatry* 2009;54:534–46.
11. Foley M, Thorley K, Denny M. 'The sick note': a qualitative study of sickness certification in general practice in Ireland. *Eur J Gen Pract* 2012;18:92–9.
12. Letriliart L, Barrau A. Difficulties with the sickness certification process in general practice and possible solutions: a systematic review. *Eur J Gen Pract* 2012;18:219–28.
13. Gerner U, Alexanderson K. Issuing sickness certificates: a difficult task for physicians: a qualitative analysis of written statements in a Swedish survey. *Scand J Public Health* 2009;37:57–63.
14. Safe Work Australia. The cost of work-related injury and illness for Australian employers, workers, and the community, 2008–2009. Canberra, Australia: Safe Work Australia, 2012.
15. Australian Bureau of Statistics. *Work-related injuries, Australia, July 2013 to June 2014*. Canberra: Australian Bureau of Statistics, 2014.
16. Safe Work Australia. Australian workers compensation statistics, 2012–2013. Canberra, Australia: Safe Work Australia, 2014.
17. Dembe A, Mastroberti M, Fox S, *et al*. Inpatient hospital care for work-related injuries and illnesses. *Am J Ind Med* 2003;44:331–42.
18. Mazza D, Brijnath B, Singh N, *et al*. General practitioners and sickness certification for injury in Australia. *BMC Fam Pract* 2015;16:100.
19. Practitioners TRACoG. *Standards for general practices (4th edition). Access to care*. East Melbourne: College House, 2010.
20. Australian Medical Association (AMA). *AMA Code of Ethics*. Canberra: AMA, 2006.
21. Medical Board of Australia. *Good Medical Practice: a code of conduct for doctors in Australia*. Providing Good Care, 2014.
22. Victorian Equal Opportunity and Human Rights Commission. *Equal Opportunity Act*. Melbourne: Victorian Equal Opportunity and Human Rights Commission, 2010.
23. Brijnath B, Mazza D, Singh N, *et al*. Mental health claims management and return to work: qualitative insights from Melbourne, Australia. *J Occup Rehabil* 2014;24:766–76.
24. Kosny A, Brijnath B, Singh N, *et al*. Uncomfortable bedfellow: employer perspectives on general practitioners' role in the return to work process. *Policy Pract Health Saf* 2015;13:65–76.
25. Department of Health. Quarterly medicare statistics. 2014.
26. McKinn S, Bonner C, Jansen J, *et al*. Recruiting general practitioners as participants for qualitative and experimental primary care studies in Australia. *Aust J Prim Health* 2014. Published Online First.
27. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
28. The Royal Australasian College of Physicians. Australasian Faculty of Occupational and Environmental Medicine. Secondary Australasian Faculty of Occupational and Environmental Medicine. <http://www.racp.edu.au/about/racp-structure/australasian-faculty-of-occupational-and-environmental-medicine>
29. The Australasian Faculty of Occupational and Environmental Medicine. *Australian and New Zealand Consensus statement on the health benefits of work*. Sydney: The Royal Australian College of Physicians, 2011.
30. Bultmann U, Franche R, Hogg-Johnson S, *et al*. Health status, work limitations, and return to work trajectories in injured workers with musculoskeletal disorders. *Qual Life Res* 2007;16:1167–78.
31. Kilgour E, Kosny A, McKenzie D, *et al*. Healing or harming? Healthcare provider interactions with injured workers and insurers in workers' compensation systems. *J Occup Rehabil* 2015;25:220–39.
32. Carlsson L, Lännerström L, Wallman T, *et al*. General practitioners' perceptions of working with the certification of sickness absences following changes in the Swedish social security system: a qualitative focus-group study. *BMC Fam Pract* 2015;16:21.
33. Department of Health. *General Practice Workforce Statistics 2014–2015*. Canberra: Department of Health, 2015.
34. Foley M, Thorley K, Von Hout MC. Sickness certification difficulties in Ireland—a GP focus group study. *Occup Med* 2013;63:369–72.