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The Work Ability Divide: Holistic and Reductionistic Approaches in Swedish Interdisciplinary Rehabilitation Teams

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Abstract *Introduction* Stakeholder cooperation in return to work has been increasingly emphasised in research, while studies on how such cooperation works in practise are scarce. This article investigates the relationship between professionals in Swedish interdisciplinary rehabilitation teams, and the aim of the article is to determine the participants' definitions and uses of the concept of work ability. *Methods* The methods chosen were individual interviews with primary health care centre managers and focus groups with twelve interdisciplinary teams including social insurance officers, physicians, physiotherapists, occupational therapists, medical social workers and coordinators. *Results* The results show that the teams have had problems with reaching a common understanding of their task, due to an inherent tension between the stakeholders. This tension is primarily a result of two factors: divergent perspectives on work ability between the health professionals and the Social Insurance Agency, and different approaches to cooperative work among physicians. Health professionals share a holistic view on work ability, relating it to a variety of factors. Social insurance officers, on the other hand, represent a reductionistic stance, where work ability is reduced to medical status. Assessments of work ability therefore tend to become a negotiation between insurance officers and physicians. *Conclusions* A suggestion from the study is that the teams, with proper education, could be used as an arena for planning and coordinating return-to-work, which would strengthen their potential in managing the prevention of work disability.

Keywords Work ability · Return to work · Cooperation · Team · Interdisciplinary

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Introduction

A multi-stakeholder or a system approach to return-to-work is supported by an increasing number of studies [1–3]. Cooperation, though identified as a cornerstone of successful return-to-work, is challenging due to incompatibilities between stakeholders regarding policies and definitions of concepts [1]. Furthermore, national systems of social insurance differ, which makes the implementation of research results into practise difficult.

In the Swedish sickness insurance system, the concept of work ability has become increasingly important due to a change of policy, where the effect of a disease on the individual's work ability is considered as the principle for eligibility to sickness insurance rather than the disease

itself. This development is in line with the trend of "activating-welfare-states" in several Western countries during the last decades, where work oriented labour market policies are commonly promoted [4, 5].

This study focuses on interdisciplinary rehabilitation teams as a cooperative work form between two central stakeholders within the Swedish sickness insurance system: the Swedish Social Insurance Agency (SSIA) and primary health care. The latter has a central role since eligibility to sickness insurance is not dependent on whether the disability is work-related or whether individuals are employed or not, which makes occupational health physicians a less central actor compared to insurance systems where eligibility is more closely tied to employment (e.g., Canada or the Netherlands).

The work ability of the individual is assessed by physicians through a medical certificate. This certificate is a legal document that the SSIA base their decision on when considering eligibility to sickness insurance and when planning the individual's vocational rehabilitation. Thus, the physicians have a central role in the system, which implies that their interpretation of the concept of work ability have an impact on eligibility to insurance. This situation makes dialogue between physicians and the SSIA a central issue.

Aim

The aim of this article is to determine how the relationship between health care professionals and social insurance officers is expressed in twelve Swedish interdisciplinary rehabilitation teams, specifically focusing on the definitions and uses of the concept of work ability.

Research Setting

In the county of Östergötland, interdisciplinary rehabilitation teams have been initiated to facilitate return-to-work for people on sick leave and to reduce the societal costs of sickness insurance by enhancing cooperation routines between health care and the SSIA. The reason for choosing Östergötland as the research setting is that the work form at the time of study was present only in this county. The work form could be considered an exception from regular Swedish practise in handling sickness insurance issues within health care, which makes a study of how the relationship between the participating stakeholders develop relevant.

In the teams, physicians, occupational therapists, physiotherapists, medical social workers and representatives from the SSIA regularly meet to discuss and plan the rehabilitation of each individual for whom sick leave has exceeded 28 days. In some of the teams, representatives from employment services, psychiatric care and social welfare offices attends team meetings. Team size varies between four and sixteen participants, where those including many participants include several physicians who participate when their patients are discussed, while teams with fewer participants commonly have a permanent consultative physician.

Team meetings take place in health centres. The frequency of meetings varies, but most commonly teams meet every 2 weeks. During the meetings, both new and old cases are discussed regarding the plan for treatment, rehabilitation and return-to-work. In every team, a coordinator (most commonly a nurse) is responsible for the administration of the meetings. The task of the coordinator is to administrate and to initiate team meetings, after which team members update themselves individually on cases through the journal system at the health care centres. Further, the coordinator is responsible for contacting the individuals to obtain an informed consent, either by meeting them or by letter.

The teams are interdisciplinary in the sense that the participants are to jointly plan the treatment; this can be contrasted with multidisciplinary work, where people from different disciplines treat patients independently and then share information with each other [6].

Work Ability in Theory and Practise

Work ability is in the literature commonly seen as determined by both individual and contextual factors. Illness and disease are examples of individual factors causing work disability, while contextual factors include the organisation of work and social relations in private or working life. An example of the latter is presented by Johansson and Lundberg [7], who suggest that the adjustment latitude and attendance requirements in workplaces have an impact on whether an individual will be able to retain their work ability and whether sickness absent will be able to return to work.

The assumption that work ability is affected not only by individual factors is supported by the WHO's International Classification of Functioning (ICF). The ICF considers functioning as dependent on six interrelated components: disease and disorders; functions and structures; activities, such as performing tasks or applying knowledge; participation in family and social life or work environment; environmental factors; and personal factors, such as age, gender and social background [8]. The ICF model has been used as a point of reference when creating schemes for assessments of function and work ability (e.g., the Norwegian functional scheme), and is also a reference in the Swedish medical certificate on work ability issued by physicians. In the Swedish system, the physicians make an

initial assessment of how the disease affects the individual's functional capacity based on the ICF. Thereafter, in the same certificate, the physicians are to assess whether the work ability is affected in relation to the individual's present occupation, and to what extent it is reduced (25, 50, 75 or 100%). Hence, the functional capacity determines the work ability in the assessments. However, the theoretical relationship between functioning and work ability is not entirely clear.

A study of Dutch insurance physicians suggest that physicians tend to focus on the "functions and structures" and "participation" components of the ICF model [9]. Previous studies of work ability assessments within the Swedish sickness insurance system shows that physicians often take non-medical aspects into account when assessing work ability, e.g., motivation for work [10, 11], indicating that both the relation between functioning and work ability and the relation between legislation and practise is unclear.

It is also of importance to note that assessments of work ability have different purposes in different countries. In most countries, instruments for work ability assessments are used for deciding upon eligibility to disability pension. Sweden differs in this respect, since the concept of work ability is equally central to the decisions on eligibility to temporary sickness benefits. It is also not entirely related to the individual's occupation; after an initial period of 6 months, work ability should be assessed in relation to the entire labour market rather than to a specific occupation. Hereby, the Swedish sickness insurance is related to work rather than occupation, which is mirrored in its financing; the employer pays for the first 2 weeks of sick-leave, after which the financing is taken over by the SSIA.

The present study does not offer a definition of the concept of work ability. Rather, the purpose of the study is to identify how the different stakeholders in the interdisciplinary teams interpret this concept and how these interpretations relate to each other.

Interdisciplinary Cooperation: A Theoretical Framework

In their study on treatment of back pain, Loisel et al. [3] propose a shift from disease treatment to disability prevention. They introduce a disability prevention management model that emphasises the involvement of the health care system as well as the workplace system, the personnel system and the compensation system in order to prevent disability and to attain sustainable return-to-work. In their model, cooperation between stakeholders is noted as a crucial factor in managing disability prevention, suggesting that interdisciplinary teams should be set up to work with the patient in order to function as consultants with the insurance system and the employer, and to provide a coherent message to the individual.

The teams in this study involve two of the systems proposed in the model: the health care system and the compensation system, which makes them a structure for interorganisational dialogue between two central stakeholders in return-to-work [3]. However, they remain solely on an interprofessional level by not involving the individual in team meetings.

Cooperation in public health settings, according to de Rijk et al. [12], is most often concerned with actors who have some sort of dependency towards one another. According to the authors, the perceived dependence rather than the objective dependence is of interest; a conclusion from their study is that one of the requirements for motivation to cooperate is the perception of interdependence. The authors also acknowledge different types of interdependence: asymmetric dependence, where power differences between involved actors are prominent; symbiotic dependence, where actors need each other to achieve their respective goals and where one goal does not disadvantage another; and competitive interdependence, where goals are in opposition to each other [12]. Further, actors generally have multiple goals: some might be symbiotic, while others are competitive. The authors also point out that goals that are initially perceived as mutual may on closer inspection prove to be divergent: the overall aim may be formulated similarly, while interpretations of the aim may differ. The actors' perceptions of each other are also central to how cooperation will work; the authors conclude that perceptions of the other and willingness to cooperate are reciprocally interrelated. From an institutional perspective, the dependence between actors and their ability to cooperate is also affected by legislation and political decisions.

In this article, the theoretical framework of cooperation will be used in order to analyse how the stakeholders in the interdisciplinary teams are interrelated and to understand what factors that may affect cooperation in this example of a cooperative work form.

Methods

In the study, the participants' perceptions, attitudes and experiences regarding team work were central. In order to make an analysis of such aspects possible, an interpretative approach was called for, and qualitative methods for data collection were used [13].

Participants and Data Collection

The material for this study was collected between October 2006 and February 2007. At the time of study, there were

forty teams in total whereof twelve were selected for inclusion in the study. The selection was made strategically to attain a suitable variation regarding the length of time the team had been working in order to make comparisons possible regarding the development of the teams. The oldest team in the study was initiated in 2001, while the remaining teams were started between 2004 and 2006. One of the teams in the study included the employment service and the social welfare office as additional stakeholders, and another team included a representative from psychiatric care. These two teams were included in order to observe whether additional stakeholders affect the dynamics of the team.

To capture the dynamics of the teams and to investigate the relationship between the participants, twelve focus groups were held, one with each team. In the focus group method, the discussion between participants concerning specific topics is central. In this method, disagreements within the groups become obvious, and generally the discussion does not result in any consensus. By using this method, a scope of perspectives on the subjects discussed is presented through interaction between participants who do not necessarily share each other's views [14, 15].

In the focus groups, teams were to discuss their work and the ways in which the new work form was put into regular practise. All in all, the focus groups involved 66 professionals, ranging from 4 to 9 participants per group. The focus groups were semi-structured, meaning that the role of the researcher was to initiate topics for discussion, but not to act as an interviewer. A highly structured form would have resulted in a group interview, and a lower level of structure might not have managed to cover the subjects of interest [15]. Topics introduced by the researcher most commonly served as starting points for the discussions. These topics were the history and the implementation of the teams, how the roles of the professionals were developed, and the practise of the teams. In the end, the focus group discussions covered a variety of issues.

Four of the focus groups were conducted by one researcher, while two researchers were present at eight of the interviews. In these cases, the second researcher had an observing role, and discussions were held between the researchers after every focus group about what had come up during the interview and how it could be interpreted.

In addition, individual interviews were conducted with the managers of the primary health care centres where the selected teams were located, i.e. 12 interviews. The focus for these interviews was a managerial perspective on how the teams have affected the daily practise of the health care centres in handling sick-listing issues. The interviews were semi-structured, based on an interview guide. The interviewees were asked about the aim of the teams, how teams were implemented, about the efficiency of the teams regarding sick-leave tenure, and how the managers perceived that the teams have affected the professionals' practise.

The focus groups lasted for between one and two hours, and were recorded and transcribed verbatim by a professional transcriber. The individual interviews lasted for between fifteen and 60 min. By request, one of the individual interviews was not recorded, but notes were taken during the interview. The remaining eleven interviews were recorded and transcribed.

Analysis and Interpretation

The analysis was performed according to the principles of a qualitative content analysis [13]. The material was read through several times to get an overall view of the content. The broad variety of issues raised in the focus groups resulted in several possible paths for analysis. The first author made a preliminary thematisation of recurrent issues in the material, covering both pre-established domains of interest (such as the work tasks and implementation of the teams and how the participants communicate with each other) and issues that arose from the discussions with the respondents (such as different understandings of work ability and changes in the medical professions). Hereby, the analysis can be said to incorporate inductive as well as deductive elements, where theoretical concepts were applied both before (theories of cooperation) and after (theories of work ability) the data collection.

The suggested themes were discussed with the co-authors, revisions were made, and new discussions followed until agreement was reached on a thematic structure that is well grounded in the empirical material and that shows satisfactory internal homogeneity and external heterogeneity, i.e. that themes are well defined and does not overlap [13]. For this article, these themes were narrowed down to focus on the relationship between health care and the SSIA regarding their perspectives on work ability.

Results

The material that has emerged from this study covers a variety of issues regarding how interdisciplinary teams are started, how they function and for what they can be used. This article focuses on the results that concern the relationship between health professionals and social insurance officers, and how this relationship affects the cooperation within the teams. This relationship can be illustrated through the following excerpt from a discussion.

> Social insurance officer: Of course, we don't look at illness—we look at work ability.

> Occupational therapist: You look at work ability and we look at illness. (Focus group 7)

Divergent Perspectives on Work Ability, Health and Disease

A recurrent theme in the material is communication problems between social insurance officers and health professionals, particularly physicians. Over the last years, the Swedish Social Insurance Agency's (SSIA) use and definitions of concepts have changed, for example the concepts of work ability and disease, where the importance of the former has been strengthened. Simultaneously, the SSIA has begun applying their regulations more strictly. In a recent change of regulations, the effect of a disease on an individual's work ability has become the criteria for eligibility to sickness insurance rather than the disease itself. A social insurance officer comments on this change.

> What has changed a lot is the SSIA's assessment of the concept of disease. I mean, what was considered a disease just a few years ago is not considered a disease today. Then of course I think of those people […] where something happens in life that affects how the patient feels, that's where nowadays the SSIA often says no to sickness benefit. (Focus group 9)

What the insurance officer says in the quote is that there has been a change in which diagnoses that qualifies an individual for sickness benefits, and that some previously recognised diagnoses have been disregarded. Further, the change of regulations implies that physicians need to state not only a diagnosis, but also in what way this disease affects the individual's work ability. This change results in increasing demands on physicians when writing medical certificates, which is a development that physicians rarely welcome. Also, the physicians often seem to disagree with the SSIA whether their patients could be considered work disabled or not. In the following quote, a discussion between a physician and a social insurance officer, illustrates such a disagreement.

> Physician: If someone's child for example have been run over and they feel really bad, you can't sick-list them […] if you follow the guidelines […]
>
> Social Insurance Officer: Well, of course, what you can do is describe it as temporary shock, stating that the plan from now on is to … And that's what's usually missing in the certificate.
>
> Physician: Well, that helps. But a state of shock? […] You've got to be really strict, what is it in the illness that reduces the patient's work ability? There's no disease that reduces his or her work ability, but there is a family problem that's really difficult—and that means that he or she can't work. (Focus group 3)

The key issue to understanding this disagreement lies in how the stakeholders define the concept of work ability. The insurance officer needs a medical diagnosis that complies with the regulations about which causes for reduced work ability that makes an individual eligible for sickness benefits. If there is no medical diagnosis, as in the example in the quote, the SSIA cannot authorise sickness benefits. Hereby, the concept of work ability is interpreted in a *reductionistic* way focusing solely on medical conditions, with disease as the only valid cause of work disability. On the other hand, the physician in the quote presents a *holistic* view on work ability, where illness or life crises makes an individual just as work disabled as if they would have had a diagnosable disease.

What the insurance officer tries to accomplish in the quote is to reformulate the situation described by the physician into a medical state; by medicalising the situation, the insurance officer complies with the physician's wish to offer the individual a period of sick-leave. Thus, what the quote illustrates is a negotiation about how to formulate a certain situation to fit into the grid offered by the regulations for sick-leave. It is therefore possible to look upon the quote as a sympathetic act from the insurance officer in trying to handle the physician's holistic views on health and work ability. Another possible interpretation is that work ability assessments are affected by individual differences in how physicians formulate their certificates, where a medicalised formulation is more likely to get accepted by the SSIA.

The holistic perspective seems to be prevalent among most health professionals in the study. Consequently, the health professionals' perception of the principal aim of the teams is rather to improve the individual's quality of life, where enhanced work ability is merely one of the potential outcomes. In the following quote, an occupational therapist illustrates the holistic perspective toward the individual.

> A lot of us, in the health care sector anyway, look at all this with a holistic view that the authorities can't have, because they have a completely different, well, job focus or whatever it is. Whereas I can see more that …, well I see my role in the team, like when I meet a patient of course I look just as much at how things work on an everyday basis, and how that person can have quality of life. (Occupational therapist, focus group 9)

Non-medical factors that affect whether an individual is able to work cannot be included in the concept of work ability when defining it through the reductionistic perspective of the SSIA. These differences in how the

stakeholders interpret key concepts imply that the SSIA and the health professionals will have different perceptions of the goals of working in an interdisciplinary team, and that there is an inherent tension between them.

Changes in Professional Roles

The tension between physicians and the SSIA is not only due to a change of insurance regulations. Another reason is a change in the medical professions toward a more cooperative stance. Both these changes have resulted in a loss of authority for physicians, towards the SSIA and towards other health professionals.

> It's this moving away from the idea of being some kind of almighty person who nobody questioned, as they do now, so of course people are quite right to question doctors just like everyone else. (Interview 8)

A reaction to this development is an increased scepticism among physicians, towards the SSIA as such, but also towards new work forms aiming for a broadened discussion of their assessments. Some physicians perceive the teams as a control system, and several respondents express weariness over the increased demands, illustrated here by a manager.

> […] you think you do a good job, and you would really like, yes, I think you would like that your judgement as a doctor would be sort of good enough as far as the SSIA was concerned. Because in some way your judgement is questioned by the SSIA, because they see other things in the certificate. (Interview 11)

Two subgroups within the physician profession can be identified from the material. One is the *traditionalist physician* who expresses sceptical views on development towards increased cooperation and who seems to grieve the loss of authority. The other is the *cooperative physician* who is more positive to a broadened responsibility for the sick leave process, where other professions are considered necessary in order to attain better assessments [16]. The following quote from a health centre manager (a physician) illustrates this cooperative view, emphasising team work as beneficial for managing long-term sick leave.

> Of course, this is a help for us too with those who tend to be on sick leave for a long time, that we sit down and discuss where we go from here, because in most cases of long-term sick leave it's not the medical part that's the difficult bit, but often it's everything else around it and how they are to move on, and then of course it's much better to work as a team. (Interview 3)

Several respondents in the study emphasise that cooperative work through interdisciplinary teams was something entirely new to them, and that the implementation of the work form was made with a top-down approach, resulting in further ambiguities regarding the purpose of the teams.

> […] the directive came from above and then all of us here were supposed to try and adjust to that […] I remember the first meetings when we didn't really understand what was intended and what the point of it was, and what form it was all going to take, and then we all had to take it back home with us, and do it in our own way. (Focus group 10)

Moreover, managers had not allocated any economic resources for the teams to create an arena for dialogue on team work. Adding this to the inherent tension regarding definitions of concepts and a general lack of introduction, the preconditions for reaching a common understanding on central concepts were not the best.

Assessing Work Ability: Could Team Work Help?

The quality of work ability assessments is negatively affected by the physicians' limited knowledge of working conditions in workplaces. This lack of knowledge leaves room for subjective interpretations from the physicians on which abilities that are needed in order to perform a certain kind of work. In such assessments, medical expertise comes second-hand.

> What they're supposed to do is to decide whether it's medical or not and how does the work ability look as far as they can decide. It's impossible to know what they're doing in a workplace, you can only, it's more about what knowledge I have as a human being and a doctor, not what my profession says or my competence as a doctor, right? This isn't about medical competence anymore. (Interview 2)

As a result, physicians tend to account for non-medical factors when assessing work ability, such as the patient's motivation for work and the social context. An implication of this is that work ability assessments may become subjectively biased. These assessments are made in the initial state of the sick leave, and they affect the further handling of the individual through the sickness insurance system as well as the health care system.

In the teams, there are professionals with more detailed insights into individuals' working conditions, e.g. occupational therapists and physiotherapists. Still, there is an ambiguity in the teams whether they are supposed to work with assessments and reassessments of work ability. Several managers view the teams as an arena where a

discussion of such assessments can and should take place. On the other hand, one manager who actually participates in a team states that the issue is not discussed at all.

> No, I can't say that, because it's usually like this, to assess work ability, you need, you need occupational therapy and physiotherapy and maybe other factors, and there's still a lack there. So I can say it like this, I miss the possibilities of fully assessing the patient. Because I can't assess this when the patient sits with me, then I can only go on the details that the patient gives me. […]
>
> But you meet an occupational therapist and a physiotherapist during the team meetings? Don't you discuss these things?
>
> No, it hasn't, no. No. (Interview 5)

Several respondents in the teams are open to using the resource of an interdisciplinary group to facilitate the assessments of work ability; particularly occupational therapists and physiotherapists mention this as one of the areas where the teamwork could be developed further. A physiotherapist notes how the cooperation with physicians in work ability assessments is generally increasing, and that physicians have started to use other professionals when assessing or reassessing patients' work ability.

> Yes, we notice that the physicians […] like to talk to us physiotherapists, like, "what work ability does this patient have?" They'll maybe meet them for five minutes or on the phone and are supposed to prolong the sick-leave on those grounds, while we meet them once or twice a week for a long time, so to speak. (Physiotherapist, focus group 11)

Time is a central factor in whether the physicians are able to make proper assessments of work ability; while physicians seldom meet their patients, other professionals meet them regularly.

So, could team work help? Many of the respondents claim that a more elaborated use of the competences represented by physiotherapists and occupational therapists are called for, and that the teams could function as an arena for such work. Thus, the results of this study identify a wish among the health professionals to improve the teams' possibilities in facilitating work ability assessments.

Summing Up

As a summary, the results may be presented in a figure, describing different approaches to two factors: work ability and cooperative work (Fig. 1). As becomes visible in the figure, both of these factors represent barriers between team members that need to be overcome in order to attain a common understanding of the work tasks of the team. There is a barrier between health professionals and the SSIA regarding the interpretation of work ability, and there is a barrier within health care between traditional and cooperative physicians regarding teams as a work form.

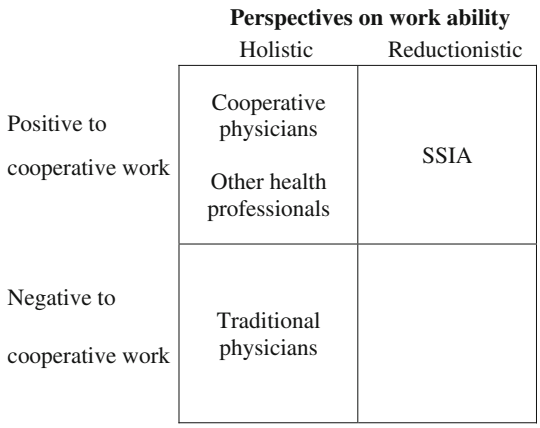

Fig. 1 Divergent perspectives in the teams

Discussion

The teams in this study have had problems with reaching a common understanding of their task, due to an inherent tension between the stakeholders regarding their perspectives on work ability, and of different approaches to cooperative work among physicians. This section focuses on the causes for this tension and on how it may be resolved.

Understanding the Tension

In order to understand the tension between the stakeholders in the teams, the theory of cooperation introduced by de Rijk et al. [12] is useful as an analytical tool. The authors emphasises stakeholders' goals, focusing on whether they are mutual or divergent. According to the authors, goals may often seem mutual at first, while proving to be quite divergent when going into depth. This situation can be recognised also in this study, where the goals of physicians and social insurance officers are both mutual and divergent. The mutual goal is a fair rehabilitation process for the individual, but the interpretation of this goal differs. Hereby, the interdependence between physicians and social insurance officers is symbiotic at the surface, while being competitive concerning means and values. In practise this means that when discussing sickness benefit issues, the stakeholders articulate the same goal, but since they mean different things when using concepts such as work ability, health or disease, they will not be able to find a common ground.

After the change of sick listing regulations, the medical certificate that physicians issue has changed so that physicians need to state in what way the disease decreases the work ability of the individual, which implies a more demanding assessment. Through this change, it has also become possible for the SSIA to question the physicians' holistic view on work ability. However, in the medical certificate the physicians are to assess how the disease limits the abilities of the individual according to the WHO's definition in the ICF model. Since the ICF's definition of functioning is broader than the reductionistic definition of the SSIA, physicians are to choose from taking either a broad or a narrow perspective on work ability. As shown in this study, physicians tend to take the broader one. Thus, this reference to the ICF in the medical certificate may work as a factor in creating the tension between the stakeholders.

As a result of the changes in regulations, the interdependence between physicians and the SSIA has gone from asymmetric to symmetric; none of the stakeholders can at the present time be considered having higher authority than the other. Although the decrease of physician authority in the sickness insurance system has resulted in a more equal relationship between the stakeholders, the tension between the stakeholders has increased, due to physicians' discontent with the change. Neither has the change made the goals of the stakeholders more symbiotic; rather, the differences have sharpened as an effect of the equalisation of authority. Thus, the physicians' loss of authority has resulted in a power struggle over sick-listing decisions.

The interdependence between physicians and other medical professions in the teams is more asymmetric, placing the physician on a higher hierarchical level than the rest. Previous research on the hierarchy of interdisciplinary teams in health care strengthens the assumption that physicians takes and receives a higher position than other professions when working together; physicians are often dominant, thereby limiting the participation of other professionals [17]. In the present study, it was obvious that teams with a strong traditionalist physician had more difficulties in attaining a constructive dialogue and to find a common ground on central concepts and issues compared to teams with cooperative physicians. Thus, the hierarchy within health care is more obvious in teams where physicians predominantly represent a traditional perspective on cooperation in sickness insurance issues. Where physicians represent a more cooperative perspective, the interdependence between physicians and other health professionals is more symmetric.

One interpretation of the asymmetric interdependence prevalent in the teams is that medical education, for both physicians and other health professions, is focused exclusively on their own profession, disregarding the fact that interdisciplinary work is an increasingly common feature in medical practise [18]. Teamwork as such is therefore contrary to medical single-mindedness and traditional medical socialisation [6, 16, 19]. Since the socialisation in health professions is strong, cooperation is dependent on changing attitudes, where a cooperative approach would imply a more clear emphasis on patient outcomes through dialogue and joint decisions [6, 16].

As noted by de Rijk et al. [12], perception of the other and willingness to cooperate is reciprocally interrelated. In the teams of this study, the prevalence of this reciprocity is indicated by the differences between teams regarding how the physicians' attitudes influence the possibility of cooperation: in teams where the relationship between physicians and social insurance officers is tense, the willingness to cooperate is negatively affected. A conclusion to be made from the focus groups is that a tense relation between the stakeholders is more prevalent in teams where the physicians represent a more traditional view of professional identity, placing less emphasis on joint learning and responsibility.

Overcoming the Divide

Despite their divergent approaches to work ability, physicians and insurance officers work together. They do so because they are required to, and they do so by negotiating how cases should be formulated to fit into the regulations, making the holistic and the reductionistic approach meet at the middle; the holistic view is expressed in a reductionistic way by formulating non-medical aspects of work disability in terms of disease. The question is often therefore not whether an individual is eligible to sickness benefit, but how the certificate could be formulated to secure that benefits will be granted. As reported elsewhere, physicians actual work has not changed, but what they write in their reports have [20].

The SSIA's emphasis on medical diagnoses places a close link between work disability and the original disorder, which implies a risk that psycho-social or work related factors of work disability are neglected in the assessments. As shown in the study, physicians' approach to work disability generally include such factors, which suggests that the noted negotiations about how to formulate certificates are more concerned with attaining a "politically correct" description of the patient than with reaching an appropriate assessment.

The teams in this study are primarily used to plan the medical treatment of the individual, using the SSIA representative mostly as a source of information on the insurance regulations. However, the results of this study suggest that an arena for interorganisational dialogue on the concept and the assessments of work ability is of need,

and that the teams possibly could function as such. In order to make the teams more efficient in facilitating return to work, the assessment of work ability could be given a more central position in the teams' work in order to make better use of physiotherapists and occupational therapists in assessing work ability.

Creating a functional team is dependent on bridging the work ability divide between health care and the SSIA in order to achieve a common understanding on the purpose of the teams. Without a proper implementation process, this is likely to take a long time. Additionally, teams need to overcome hierarchical tensions in which the physicians' attitudes play an important role.

Previous studies of cooperation in health care show that a discrepancy of values is common [21]. However, a study of Loisel et al. [22] suggests that a targeted educational effort can result in a more coherent team where the values of the participants are more centred on the team's objectives and on team unity. This strengthens the assumption that the teams in this study could have been more coherent if the implementation process would have been done more carefully. It is possible that the teams, with proper education, could function like a return-to-work coordinator instead of being occupied with planning medical treatment.

Relating to the Disability Prevention Management Model presented by Loisel et al. [3], the teams in this study comprise two of the systems proposed as central: the health care system and the insurance system. In order to create a work form that efficiently manages return-to-work and disability prevention, the other two systems would also need to be included, i.e. the personal system and the workplace system. There are also studies that suggest that the individual him-/herself are likely to make a good prediction of his/her return to work [23].

If the teams in this study would embrace the ideas of Loisel et al. [3], they should consider inviting the individual and his/her employer to the team meetings. Though, involving these stakeholders would imply a radical change of the team structure towards a larger team whose meetings could hardly manage more than one or a few cases per meeting. Therefore, there is a risk that the teams would become too time consuming and difficult to administrate. It should be noted that some of the teams has included the Public Employment Services as an additional stakeholder, which adds some knowledge on the workplace system into the discussions. However, this was at the time of study uncommon.

Methodological Considerations

The design of this study was made to assure a fair representation of the experiences and perspectives of the respondents and their views on the topics in focus. The selection of respondents was made with regard to possible cases for bias, such as how long teams had been working together, and which stakeholders that participated in the teams. However, the study was not able to identify any of these factors as central to the teams' functioning. Instead, the results show that teams differ substantially more regarding what attitudes that are most common among physicians than regarding the time the teams has been working. Further, no major differences could be identified in teams with additional stakeholders regarding the work ability divide or perspectives on cooperative work. Though, it should be noted that these conclusions could be the result of the limited number of teams included in the study.

The credibility of the study is strengthened by the co-authors' examinations of the analytic process, and the results and manuscripts have been discussed thoroughly, in order to attain trustworthiness in Lincoln's and Guba's sense of the word [24]. The results have also been validated through reporting back to the respondents and the managers responsible.

In the focus groups, topics were both initiated by the researchers and the participants; though, it is possible that the results would have been different if the researcher had raised other topics for discussion. The analysis was primarily carried out by using empirically grounded themes, which was related to a theoretical structure. The approach therefore had both inductive and deductive traits.

Qualitative studies generally lack the possibility of generalisation to a broader population in a statistical sense. However, there is no reason to assume that the teams in this study are unique. The conclusions from this study may serve as a foundation for future comparisons and hypotheses.

Conclusions

The results of this study show that the teams have had problems with reaching a common understanding of their task, due to an inherent tension between the stakeholders. This tension is primarily a result of two factors:

1. Divergent perspectives on work ability between the health professionals and the SSIA, where the former represent a holistic approach, considering a variety of factors as contributing to an individual's work ability, while the latter represent a reductionistic approach, considering only disease as a valid cause for work disability; and
2. Different approaches to cooperative work among physicians, where "traditional" physicians' dissatisfaction with changes in sickness insurance regulations negatively affects the possibilities of cooperation.

A suggestion from the study is that the teams, with proper education, could be used as an arena for planning and coordinating return-to-work, which would strengthen their potential in managing the prevention of work disability.

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Authors' contributions CS: study design, fieldwork, first draughts of the analysis and writing the text. KE: study design, examining and commenting on the analysis and the manuscript. TS and GP: examining and commenting on the analysis and the manuscript.

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