Chapter 5

Expectations and opinions of work disability claimants and their physicians about the communication during the disability assessment interview

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Abstract

**Introduction:** This study set out to shed light on how claimants’ prior expectations about communication in an assessment interview differ from their opinions afterwards, and how claimants’ opinions differ from the interviewing physicians’ perceptions of these opinions.

**Method:** 53 work disability claimants completed questionnaires before and after the work disability assessment interview, and 28 social insurance physicians did so after the interview. Wilcoxon tests were performed to determine the significance of differences between the answers on the different questionnaires.

**Results:** The results revealed significant differences between claimants’ expectations and opinions on three out of four communication components (viz. Listening, Correctness and Clarity, but not Empathy), where claimants with a low level of education showed significant differences on all components (including Empathy). Claimants’ opinions differed significantly from the physicians’ perceptions of them on two out of six communication components (viz. Correctness and Diligence).

**Conclusions:** We conclude that claimants are reasonably satisfied about communication after the assessment interview, despite their somewhat unfavourable prior expectations. Social insurance physicians are reasonably capable of accurately judging claimants’ opinions about the communication. Nevertheless, they frequently tend to err on the favourable side. It would be worthwhile to incorporate these findings in communication skills training courses for social insurance physicians.
Introduction

Employees in the Netherlands who are chronically (totally or partially) prevented by illness from performing paid work may apply to the Institute of Employee Benefit Schemes for disability benefit when the duration of the illness approaches two years. A work disability assessment interview with a social insurance physician of this Institute, possibly followed by an interview with an employment expert, form the basis of the decision on whether the sick employee or claimant will receive benefit, and, if so, which type [1]. The assessment interview is therefore an important step in the assessment process, and much is at stake for claimants. Claimants moreover find the event stressful [2;3], which is reinforced by unfamiliarity with the physician [3] and perceived power differences [2]. On the other hand, research has shown that effective communication on the part of the physician reduces claimants’ signs of stress [4] and increases their acceptance of the physician’s advice [5]. The manner of communicating with and handling claimants during assessment interviews is therefore essential [6], as is the quality of the communication, which physicians themselves also emphasise [7].

As the assessment interview proceeds, both the physician and the claimant will form an opinion about the quality of the communication. These opinions may well correspond with prior expectations, but this aspect has never been investigated. However, research has suggested that high claimant expectations – moderated by personal experience and the sociopolitical context – can be detrimental to the evaluation of the quality of care [8], and Dutch research has revealed greater satisfaction with GP out-of-hours surgeries when patients’ expectations are confirmed [9]. It has also been shown that claimants’ expectations about communication with social insurance physicians are not always confirmed [6]. How effectively health care professionals meet patients’ expectations about their reciprocal dealings and communication can be viewed as a measure of the quality of the physician-patient contact [10,11]. The ultimate opinion about the communication is therefore affected significantly by any difference between prior expectations and reality, and the direction of the difference. For instance, an interview that proceeds reasonably well will be more likely to be evaluated positively if prior expectations were unfavourable than if they were favourable. It is therefore difficult to identify the general attributes of communication during an assessment interview that constitute ‘good quality’. Furthermore, it cannot be taken for granted that smooth communication will lead to a good quality outcome of the assessment process, or vice versa. In other words, it is easier to study opinions about the communication than the associated quality.

If the claimant’s opinion about the communication is known, it is then important to know how it relates to the physician’s opinion. Accommodating claimants in the communication during an assessment interview, and taking account of claimants’ opinions about the communication, require the physician to be clearly aware of these
opinions. However, claimants are unlikely to express them explicitly and spontaneously. The most obvious way for a physician to discover these opinions is to interpret claimants’ behaviour and to read the underlying message between the lines of what they say. However, physicians’ capabilities may vary in this respect, or, alternatively, the correctness of their judgment about the claimant’s opinion may be affected by the contrast in the contexts from which physicians and claimants enter the interview, and their disparate interests in the interview. For instance, there are differences in prior knowledge (the physician is performing everyday work, while the claimant will probably be in an entirely new situation), the position of power, and the respective aims. The physician will be primarily interested in efficient interview progress, while the claimant will want to explain his/her situation as completely as possible. A greater understanding of the situation may come from comparing the claimant’s opinions about the communication with the physician’s perceptions of these opinions.

This study focused on the following questions:

I. On which components did claimants’ expectations prior to an assessment interview about the communication with a social insurance physician differ from their opinions after the assessment interview?

II. On which components did claimants’ opinions (after the interview) about the communication with the social insurance physician differ from social insurance physicians’ perceptions of these opinions?

Methods
Participants
Approximately 360 claimants were approached for the study through the Institute of Employee Benefit Schemes. The criteria for inclusion were: invited for a work disability assessment interview, and able to attend at the Institute’s offices. The criteria for exclusion were: employed by the Institute, resident abroad, and insufficient command of the Dutch language to complete questionnaires.

Data collection
Questionnaires were administered from March 2008 to the end of July 2008. All questionnaires were sent to the respondents by post, and all respondents gave ‘informed consent’.

The first questionnaire (T1) was a general questionnaire for claimants to be completed prior to the assessment interview. This questionnaire asked about the expectations about the communication with the social insurance physician during the assessment interview. T1 also solicited additional demographic data, such as age and gender. Subsequent to the assessment interviews the same claimants who had completed the first questionnaire answered a second questionnaire (T2a), and the
physicians who assessed them completed another questionnaire (T2b). The participants were requested to complete the questionnaires as soon as possible after the assessment interview. At the time of completion the cases had yet to be reviewed by an employment expert, and the final outcomes of the claim assessments were unknown. The questions of T2b corresponded with those of T2a, but were phrased from a different perspective: claimants were asked how they assessed the communication with the physician, whereas physicians were asked about their perceptions of the same claimants’ observations of the communication.

**Questionnaires**
This study sought to comply with the Institute of Employee Benefit Schemes Claimants Monitor [12], which has the following subjects: Listening, Empathy, Correctness, Clarity, Diligence and Expertise. The following questions were included for each of the subjects, as one of the most important aspects of the subject. The last two subjects were included only for questionnaire part 2. All answers to the questions were given on a 5-point scale with, depending on how the question was phrased, answer categories of ‘no/I don’t think so/undecided/I think so/yes’ or ‘completely disagree/partly disagree/neutral/partly agree/completely agree’.

- **Listening**:
  - T1: Please indicate how much you do or do not expect the following in the interview with the social Insurance physician: the physician will listen to me.
  - T2a: Did the physician listen to you well during the interview?
  - T2b: The claimant was of the opinion that I listened to him or her during the interview.

- **Empathy**:
  - T1: Please indicate how much you do or do not expect the following in the interview with the social Insurance physician: the social Insurance physician will put me at ease during the interview.
  - T2a: The physician put me at ease at the start of the interview.
  - T2b: The claimant felt more at ease as the interview progressed.

- **Correctness**:
  - T1: Please indicate how much you do or do not expect the following in the interview with the social Insurance physician: the physician will ask me questions that I will find uncomfortable.
  - T2a: Did the physician ask you questions you thought were suggestive (questions that appeared to push your answer in a particular direction) and/or did the physician make any remarks that you found offensive?
  - T2b: The claimant found some of my questions and remarks suggestive and/or offensive, although that was not my intention.
Clarity:
- T1: If you think ahead to the interview with the social insurance physician, how likely do you think it will be that you understand what the physician tells you?
- T2a: Did the physician use words that you understand?
- T2b: The claimant thought I used clear language (not jargon).

Diligence:
- T2a: It was apparent during the interview that the physician was sufficiently familiar with my file.
- T2b: The claimant noticed that I was sufficiently familiar with his/her file.

Expertise:
- T2a: The physician appeared to me to be an expert.
- T2b: The impression the claimant had of me and the way I work was expert.

**Analyses**

With a view to answering the first research question, Wilcoxon tests were performed to determine the significance of differences between claimants’ answers to questionnaire T1 prior to the assessment interview and their answers to questionnaire T2a after the assessment interview. Wilcoxon tests were also performed in order to answer the second research question, to determine the significance of differences between claimants’ answers to T2a and physicians’ answers to T2b. The reason for also testing the second research question for dependent samples is that the physicians’ and the claimants’ answers are always in correspondence: all are concerned with a social insurance physician and a claimant who were present at the same assessment interview. In addition to analyses for the entire group, subanalyses were performed for the group of claimants with a high level of education (general secondary or higher) and those with a low level of education (junior general secondary or professional, or lower). Statistical significance was set at $p<0.05$. All analyses were performed using SPSS 15.0. The means and standard deviations were calculated from the answers and shown in a graph.

**Table 5.1**: Distribution of level of education of the participating claimants ($n=53$).

<table>
<thead>
<tr>
<th>Level Completed education$^a$</th>
<th>High (n=22)</th>
<th>Low (n=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>University</td>
<td>HPE</td>
</tr>
<tr>
<td>Number of claimants</td>
<td>3</td>
<td>13</td>
</tr>
</tbody>
</table>

$^a$ Highest completed education with certificate: University = university education; HPE = higher professional education; GSE = general secondary education; SSG/PE = senior secondary general or professional education; LSVE = lower secondary vocational education; None = no education or lower school.
Results

Participants
Of the claimants approached, 53 (15%) took part in the complete survey. They were assessed by 28 social insurance physicians. There were fourteen social insurance physicians who each saw one participating claimant, seven who saw two, four who saw three, two who saw four, and one who saw five. The respondents were from all parts of the Netherlands.

Of the claimants, 40.4% were male and 59.6% female, and 73.1% had a partner. Ages varied between 23 and 63, with an average of 48.5 years (SD=8.9). 98.1% of the claimants were of Dutch origin. The educational level is given in Table 5.1. Of the claimants, 61.5% are currently employed in a paid job. The commonest self-reported disorders were locomotor system and psychiatric symptoms (both 21.2%), followed by a combination of the two (13.5%). Two claimants lodged a complaint about the communication after the interview, and seven objected to the conclusion.

The 53 claimants did not differ from the complete group of claimants in terms of gender and main diagnosis. They did differ in terms of age. Our sample included relatively senior claimants than the total group.

Question I: differences between prior expectations and later opinions
The mean scores on each of the communication subjects concerned with claimants’ expectations and opinions are shown together with the standard deviations in Figure 5.1.

![Figure 5.1: Means and standard deviations of expectations of claimants, opinions of claimants, and opinions of claimants according to social insurance physicians, about the communication with the social insurance physician during the assessment interview.](image-url)
5.1. Claimants’ expectations for all four of the communication components were lower than their opinion after the event. This difference is statistically significant for Listening ($p=0.026$), Correctness ($p<0.00$) and Clarity ($p<0.00$). Looking at the subgroups of participants with a high and with a low level of education, as opposed to the entire group, there is a significant difference between expectations and opinions for the low level of education group on all communication components, whereas there were significant differences for the high level of education group only on Correctness and Clarity. The means and standard deviations for the subgroups are shown in Figure 5.2.

**Question II: differences between claimants’ and physicians’ opinions**

The respective mean values of the claimants’ and the physicians’ opinions about the communication subjects are shown together with the standard deviations in Figure 5.1. Claimants have the highest expectations for the physician’s listening behaviour (4.0 on a scale from 1 to 5) and the lowest for correctness (2.3 on a scale from 1 to 5). Claimants’ opinions after the interview fluctuated around a score of 4 on a scale from 1 to 5. Clarity and listening behaviour received the most favourable assessments after the event, and empathy the least favourable. The physicians’ opinions about all subjects were conspicuously more favourable than the claimants’. This difference is significant for Correctness ($p<0.00$) and Diligence ($p=0.008$). If we single out the subgroups with a higher and lower level of education, the only significant difference

![Figure 5.2](image_url)

**Figure 5.2**: Means and standard deviations of expectations of claimants, opinions of claimants, and opinions of claimants according to social insurance physicians, about the communication with the social insurance physician during the assessment interview, shown separately for claimants with a low level of education (Low) and claimants with a high level of education (High).
between the opinions of claimants and physicians would appear to be for the Correctness communication component. There was a significant difference on Correctness for participants with a higher level of education. The means and standard deviations for the subgroups are shown in Figure 5.2.

**Discussion**

**Main findings**
The results of this study show no significant difference for Empathy between claimants’ expectations about the communication prior to the assessment interview and their opinions after the event. There was a difference for the Listening, Correctness and Clarity communication components. Looking specifically at the subgroup of participants with a lower level of education, expectations differ significantly from opinions on all communication components. Claimants’ opinions (after the interview) about the physician’s communication during the assessment interview differed on Correctness and Diligence from the physician’s perception of their opinion. Social insurance physicians’ opinions on these communication components were more favourable than those of the claimants.

**Interpretation**
The results of the first research question show differences between the claimants’ expectations prior to an assessment interview and their opinions after the event. There appear to be a greater number of differences for claimants with a lower level of education than a higher level. This picture is not entirely consistent with the results of a study of chronically ill and disabled people, in which the patients stated that the interview with the social insurance physician met their expectations about the communication reasonably well [6]. A difference in level of education cannot be the explanation, since the mean level of education of the participants in this study was lower than in ours. However, the cause of the difference could be that the findings in the other study were not categorised according to subject.

The results of the second research question suggest that social insurance physicians are poor judges of claimants’ opinions on several communication components, but judge other subjects well. It would appear that physicians tend not to observe claimants’ low opinion of the physician’s correctness and diligence. Social insurance physicians then judge claimants’ opinions more favourably than is actually the case. This could point to ‘self-enhancement bias’ among social insurance physicians: in other words, an excessively favourable evaluation of themselves through interpreting the situation to their own advantage [13,14]. These findings suggest that social insurance physicians are not absolutely capable of responding satisfactorily to claimants’ opinions about the communication during assessment interviews.
The findings of this study could be explained by claimant characteristics. Level of education appeared to have a part in expectations, but had less to do with differences in opinions. Other possible claimant characteristics include the number of functional opportunities, or agreement or disagreement with the physician’s opinion. However, supplementary analyses – which are not included in this article – show that these characteristics have no major role in the present study.

**Strengths and weaknesses**

An important strength of this study is that it incorporates the views of both claimants and social insurance physicians on the same assessment interview, which has not been done previously in this way. Furthermore, the study took place in the framework of an academic study conducted by an independent organisation, which reduces the probability of socially desirable answers. A relative weakness is that this study involved separate questions, not validated scales. Furthermore, discussion is possible about the timing of completing the T2 questionnaires. Our choice was to administer these questionnaires as soon as possible after the assessment interview, with a view to minimising interference from other factors, such as the opinions of a partner, or events in the interview with the employment expert. However, it could also be beneficial to have the questionnaire administered only at the end of the complete assessment, or both after the interview with the physician and after the interview with the employment expert. However, these approaches were infeasible in the present research design.

Only 15% of the claimants approached were willing to complete both questionnaires. One of the reasons for this low response was a practical aspect of the research design: claimants had only a short time to decide whether or not to participate and to complete the first questionnaire. This was because they received the information about the study at the same time as the invitation for the assessment interview. An important possible consequence of the low response is that the results of this study can be generalised only to a limited group of claimants. For instance, we showed that the participants were relatively senior on average, and it is also probable that more people with a high level of education and Dutch nationals took part than are present in the cross-section of Institute claimants. It is possible that modifications to the study, such as the option of a telephone interview, or translated questionnaires, would have increased the response. However, these approaches could not be used in the present study.

It was impossible in this study to incorporate the final outcome of the work disability assessment (i.e. the amount, if any, of the benefit). It was consequently impossible to adjust the analyses of claimant satisfaction for the influence of the final outcome. However, it is probable that claimants’ opinions about the communication are influenced by this outcome, or, more in particular: by how closely the outcome corresponds with what the claimant wants. While completing the second questionnaire
claimants did not know the result of the assessment, but will have had a certain expectation, based on what the social insurance physician said about the conclusions in the course of the interview. If claimants’ expectations correspond with their wishes, it may bias claimants’ opinions in a favourable sense (i.e. the communication would be assessed more positively). If the expectations do not correspond with their wishes, the bias may be in an unfavourable sense. Because both situations may arise in this study, we would expect them to average out (at least partially). We therefore do not expect the possible net influence on our research results to be large.

**Implications for practice**

Claimants are reasonably satisfied with the communication, with assessments around 4 on a scale from 1 to 5. However, there is more to be gained for the social insurance physician. It would be worthwhile investigating whether and how social insurance physicians could adapt their communication behaviour to give claimants a greater sense of the physician’s empathy with the stressful nature of the assessment situation for them. On the one hand, training in the more correct phrasing of questions addressed to claimants, and greater diligence in preparation, are advisable, and likewise in improving judgment of – or asking about – claimants’ opinions of the communication during the assessment interview. On the other hand, an intervention could be directed to claimants and their pattern of expectations. For instance, changes in the provision of information could help claimants acquire more realistic expectations. Better adapted communication and a greater understanding of claimants’ opinions and perceptions would benefit the communication and thereby promote efficient information collection within the framework of work disability assessment.

**Conclusions**

Claimants’ expectations about the quality of the communication during assessment interviews with social insurance physicians are generally reasonably favourable. However, these expectations appear to be less favourable than claimants’ opinions after the interview with respect to half of the communication components considered, and in the case of people with a lower educational level, even with respect to all the components. Social insurance physicians would appear to be reasonably capable of judging claimants’ opinions about the communication. Their assessment tended to be too favourable.

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