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ORIGINAL ARTICLE

## Problems in sickness certification of patients: A qualitative study on views of 26 physicians in Sweden

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### Abstract

**Objective.** To identify what problems physicians experience in sickness certification of patients. **Design.** Qualitative analyses of data from six focus-group discussions. **Setting.** Four counties in different regions of Sweden. **Participants.** Twenty-six physicians strategically selected to achieve variation with regard to sex, geographical location, urban/rural area, and type of clinic. **Results.** The problems involved four areas: society and the social insurance system, the organization of healthcare, the performance of other actors in the system, and the physicians' working situation. In all areas the problems also involved manager issues such as overall leadership, organization of healthcare, and existing incentives and support systems for physicians' handling of patients' sickness certification. Many physicians described feelings of fatigue and a lack of pride in their work with sickness certification tasks, as they believed they contributed to unnecessary sickness absence and to medicalization of patients' non-medical problems. **Conclusions.** The problems identified have negative consequences both for patients and for the well-being of physicians. Many of the problems seem related to inadequate leadership and management of sickness certification issues. Therefore, they cannot be handled merely by training of physicians, which has so far been the main intervention in this area. They also have to be addressed on manager levels within healthcare. Further research is needed on how physicians cope with the problems identified and on managers' strategies and responsibilities in relation to these problems. If the complexity of the problems is not recognized, there is a risk that inadequate actions will be taken to solve them.

**Key Words:** *Clinical practice, family practice, leadership, physicians, quality of health care, sickness certification, sick leave, working conditions*

Sickness certification is considered to be an aspect of patient treatment and is, in Sweden, supervised by the National Board of Health and Welfare [1]. Physicians are responsible for issuing sickness certificates, assessing the need for rehabilitation, and when needed, establishing contact with other professionals outside or inside healthcare [2]. Previous research has indicated that physicians' sickness certification practices vary widely [2]. Risks of patients safety, low quality of care, and negative effects on the well-being of physicians have been suggested [1,3] and the situation seems to be the same in most Western countries [2,4].

A recent systematic review of studies on physicians' sickness certification practices [2] could establish

evidence for that physicians find sickness certification problematic. However, only a few studies have identified what problems physicians actually experience [4–12]. More knowledge on this is needed to improve handling of sickness certification issues within healthcare.

Our objective was to identify what problems physicians experience in their work with sickness certification of patients.

### Material and methods

Data from six focus-group discussions (FGDs) with physicians were subjected to qualitative analyses.

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There is evidence that physicians find sickness certification problematic, but until now only certain aspects of the problems have been described in a limited number of studies.

This study found that:

- Physicians experience problems related to four areas that all include leadership issues. Therefore, the problems cannot be solved merely by training physicians, which has previously been the main intervention in this area.
- The problems must also be addressed on manager levels within healthcare to avoid negative consequences both for patients and for the well-being of physicians at work.

### *Selection of participants*

Participants were strategically selected to include physicians from different regions of Sweden, from urban and rural areas, and from clinics where sickness certification is a common task [13], including primary healthcare (GPs), orthopaedics, psychiatry, rehabilitation medicine, and obstetrics. The groups were made as homogeneous as possible to promote free communication [14]. Addresses of physicians in the chosen areas were obtained from a database covering all physicians in Sweden. Invitations to take part in an FGD were sent to 380 physicians in order to create a sufficient number of physicians meeting the inclusion criteria [14]. A total of 32 of the physicians agreed to join. Reasons for not participating were other appointments, lack of time, or that no financial compensation was offered. Six physicians did not show up. In all, 26 physicians (50% women) participated in six FGDs, with two to six participants per group (GPs in three groups).

### *Data collection*

FGDs were used to obtain as many perspectives as possible on the research issue [14]. A discussion guide was constructed based on findings in the literature, pilot interviews [3], and deliberations among the authors. A grounded theory approach was used in collecting data; the guide was continuously developed to ensure that all important areas were covered [15–17]. The general question asked was: “What problems do you experience when sick leave for a patient is considered?” The areas of competence, waiting times, role conflicts, cooperation, responsibility of the

physician, handling of referrals, and leadership and management were covered in the guide. If these aspects did not arise spontaneously in the discussions, they were introduced as open-ended questions.

The FGDs were conducted in 2004 in four counties in Sweden, in connection with the participants’ worksites. Data collection was ended when saturation was reached [14]. The first and second author alternated, taking the role of either facilitator or observer in a group. The facilitator served as moderator and explained the purpose of the discussion and aspects of confidentiality. The participants were encouraged to speak freely and share their specific individual views and thoughts on the subject with the other members of the group. They were informed that they had the right to withdraw from the study at any time. Each FGD lasted approximately 90 minutes and was audiotaped. The tapes were transcribed verbatim.

### *Data analysis*

Qualitative analysis was performed, using content analyses [18]. Initially, the four authors independently identified all statements that concerned problems in sickness certification of patients. Only statements where consensus could be reached that they described a problem for the physician were included in the analyses. More than 600 such statements were identified and then coded using NVivo software. The first level of coding was discussed and decided on in consensus between the first and second authors. Subsequent levels of coding were completed by the first author. Coding principles and emerging categories were discussed regularly and decided on through negotiated consensus among the authors. This strategy ultimately led to identification of problems in four main areas, each of which comprised several categories and subcategories. In the results section, the categories are illustrated by direct quotes from the interviews, using // to indicate that text has been omitted, and () to show that text has been added. All additions and omissions were made for practical reasons, and have not changed the meaning of the statements.

### **Results**

Four different areas of problems were identified: (A) society and the social insurance system, (B) the organization of healthcare, (C) the performance of other actors in the system, and (D)

Table I. Areas and categories of problems in sickness certification of patients as experienced by physicians in Sweden.

A. Society and the social insurance system	B. Organization of healthcare	C. Performance of other actors in the system	D. The physicians' working situation	
<ul style="list-style-type: none"> <li>● Policies and laws</li> <li>● Different levels of compensation in the social insurance system</li> <li>● Changes in the labour market</li> <li>● Lack of overview and management</li> </ul>	<ul style="list-style-type: none"> <li>● Lack of leadership and management</li> <li>● Not enough physicians in primary healthcare</li> <li>● Referral systems and fragmentation of care</li> <li>● Routes of contact and access</li> </ul>	<ul style="list-style-type: none"> <li>● Communication with the social insurance office</li> <li>● Cooperation with other stakeholders</li> <li>● Actions of other physicians</li> <li>● Actions of other healthcare professionals</li> <li>● Patients' attitudes</li> </ul>	<ul style="list-style-type: none"> <li>● Handling patients with symptoms difficult to diagnose (i.e. physical or mental pain)</li> <li>● Assessing patients' work ability</li> <li>● Lack of advice and counselling from other professionals</li> <li>● Handling the various roles as a physician</li> <li>● The lack of scientific knowledge on consequences of being sickness absent</li> </ul>	<ul style="list-style-type: none"> <li>● The action orientation in the physicians' profession</li> <li>● Ethical dilemmas</li> <li>● Physicians' psychosocial working conditions</li> <li>● Medicalization of patients non-medical problems</li> <li>● Contribution to prolonged/non-optimal sickness absence</li> </ul>

problems related to the physicians' working situation (Table I).

*(A) Problems related to society and the social insurance system*

The physicians experienced an imbalance between the *policies and laws* that regulate sickness benefits and the complexity of the situations they met in their practice. Many experienced that patients “fell through the cracks” in the social insurance system, leading to unnecessary or prolonged sick leave. The fact that *levels of compensation vary in different parts of the social insurance system* was considered to make patients prefer sick notes, as sickness benefits usually are higher than unemployment benefits or social allowances. *Changes in the labour market* involving fewer “‘easy’ jobs”, higher demands on employees, and a decrease in rehabilitation efforts made by employers were described as major obstacles to new or continued employment or return to work (RTW) after being off sick. There were statements indicating that employers no longer adjusted the working situation to facilitate RTW. The physicians also referred to a *lack of overview and management* of the social insurance system as a whole, which was described in terms of unclear responsibility and instructions from the authorities concerning the purpose of the system. Some believed that there were hidden agendas, such as politicians deliberately using the sickness insurance system to hide unemployment in society. (See Box A).

**Box A. Problems related to society and the social insurance system**

“... the rules (stipulate) that a person must be completely incapable of performing any conceivable form of work, and when it is no longer possible to even consider any type of work, due to the situation on the labour market, it's very hard.”

“Of course this (the sickness certification system) should have some kind of guidance // I mean some other type of management // that includes more extensive cooperation between (the various organisations).”

*(B) Problems related to the organization of healthcare*

*Leadership and management* of sickness certification procedures were described as lacking, being counter-productive, or inadequate concerning policy, support, and quality control. The physicians were clearly uncertain where responsibility for sickness certification issues lies within the healthcare organization, and none of them could identify anyone in charge of such questions in their clinic, hospital, or county. Existing gearing systems and incentives were also considered problematic. Financing of healthcare, usually based on the number of consultations rather than the type, was described as making it difficult to take the time needed to motivate patients to RTW, to write correct certificates, and to assess the need for sickness

absence. *Not enough physicians in primary healthcare* was described as worsening these problems. Problems associated with *referral systems and fragmentation of care* between hospital clinics and between primary and hospital care were considered to result in prolonged and passive sickness absence during waiting periods. Another problem was related to the *routes of contact and access*, exemplified by patients who present at emergency wards to obtain a sick note due to long waiting times to see GPs. The “emergency thinking” on the emergency wards was described as “spilling over” to the handling of sickness certification, and patients tended to receive sick notes “on the spot” without physicians asking questions or giving directions for follow-up. (See Box B).

**Box B. Problems related to the organization of healthcare**

“Considering the enormous amount of money that is available to us as doctors // and when you hear the actual figures, in regard to both medicines and sickness certification, it is obviously very alarming. And, what’s more, no one checks (this) at all. If you work at a bank // there have to be at least two people who check...”

“One of the reasons for the length of sickness certification is that we don’t have time for follow-up appointments. My first available time is (in five weeks) ...”

“(Patients presenting at the emergency ward) result in very poor continuity. Obviously, no assessment of work capacity will ever be done, if there is just a series of emergency visits.”

*(C) Problems related to the performance of other actors in the system*

*Communication with the social insurance office* was the dominant problem in this area. In some regions the physicians seemed engaged in a “mental battle” with the social insurance staff, manifested in the pattern of communication. Physicians recounted several cases where there was no oral communication at all with the social insurance staff, interactions taking place only in writing. They described long series of certificates for particular patients that were returned with “ridiculous” demands for clarification, and social insurance staff who ignored invitations to participate in rehabilitation meetings. Also the design of the certificate was described as problematic. Problems in *cooperation with other stakeholders* such as

employers, the unemployment office, and the social welfare office were also mentioned.

Another category in this area was *the actions of other physicians*. This concerned hospital physicians “dumping” sick-listing cases onto GPs despite their long waiting times, GPs too hastily referring cases to orthopaedics leading to prolonged sick-leave spells, and problems with private practitioners regularly referring patients to public GPs when extended sickness certificates are warranted. The physicians also described that “other” physicians were governed by their personal attitudes and political opinions in their sick-listing practices. Problems related to *the actions of other healthcare professionals*, such as midwives and “therapists” demanding sick notes for their patients, were also mentioned.

Another category was *patients’ attitudes*, which sometimes was described as a problem in itself. Examples of this included patients too contented with being sickness absent, patients who had lost their self-esteem during sick leave, patients who demanded to be sickness certified, or, on the contrary, patients who did not want to be off sick even though this was recommended by the physician. (See Box C).

**Box C. Problems related to the performance of other actors in the system**

“(Staff at) the social insurance offices can sit at (rehab meetings) all afternoon, while we rush around like crazy //. It’s like we just don’t understand each other. And then we have slightly different jargon, too, which I also think is difficult. And I have a feeling that // they don’t really have a clear picture of their jobs. // it’s awfully hard for us...”

“I have issued 17 sick notes on which I ticked the last box, you know (that I want a joint rehab meeting) // ... no one contacts you. So the next time I write that if you actually read what I have written on the certificate at all, you can call me on my mobile, which is on round the clock. I don’t hear anything from them. So I call the case manager, they have changed this 25-year-old fellow’s case manager eleven times.”

“When I started (working at the primary healthcare center), it was probably the worst thing I had ever experienced, because there was one physician suffering from burnout who had certified sickness absence as much as possible just to survive. And then there were the people on sick leave, one for six or eight years due to fractures! A foot with a fracture that was

sustained six years ago! To annul that type of long sickness absences takes sort of an enormous amount of work...

"... there are many who have been on sick leave for a long time who also put up with it fairly well. I mean that (a person) has reckoned that if I work full time or if I am off sick, if I get 75% of my pay, then I'll live on nearly the same level. // I know that several of my patients actually feel rather comfortable with this."

#### (D) Problems related to the physicians' working situation

The physicians, especially GPs, described several problems in handling sickness certification issues for *patients with symptoms difficult to diagnose, such as physical or mental pain*. They felt that the number of patients in this group had increased, and that they did not know how to treat and rehabilitate those patients. Another problem was *how to assess work ability*, and not having access to *advice and counselling* from other professionals when needed, such as psychologists, physiotherapists, psychiatrists, or orthopaedic specialists. The physicians also found it difficult to *handle their various roles* in relation to sickness certification, for instance being "patient's advocate", medical expert, and gatekeeper. Moreover, they pointed out the *lack of scientific knowledge on the consequences of being sickness absent*. Expectations, from others as well as from themselves, to be *action oriented* were also highlighted as a problem. Some of the physicians seemed to experience writing the certificate almost as "giving a gift", to do at least something for a patient when not knowing what other action to take.

Problems concerning *ethical dilemmas* included aspects such as not wanting to worsen the situation for already vulnerable patients by refusing to certify absence and thereby forcing them into unemployment and lowered benefits. The *psychosocial working conditions* of physicians were also mentioned as a problem. This can be seen as a consequence of the other problems, but also had an impact on the way the physicians handled sickness certification tasks. Many of the physicians, particularly GPs, were aware that they did not do a good job with their patients concerning sick-listing, and they reported fatigue, despair, and a lack of pride in their work as consequences of this. Due to many of the problems mentioned, the physicians also felt that they contributed to *medicalization* of their patients' non-medical problems and to *prolonged or in some way non-optimal periods of sick leave*. (See Box D).

#### Box D. Problems related to the physicians' working situation

"This responsibility ... our dual roles, we are supposed to be the patient's advocate on the one hand, and then of course consider costs as well. Someone has said that every physician annually generates one million in sickness benefits expenditures."

"The problem (is often) a functional impairment due to something that is not necessarily a disease. But to adjust life to functional impairments a diagnosed disease is required, because that's the only way to get benefits when you cannot work full time."

"You can have consultations with four depressed pain patients in one afternoon. And then you're neither a good doctor nor especially pleasant when you get home, on the contrary, you actually feel pretty awful yourself."

"... I think it's difficult to certify sickness absence for the right people and for the appropriate length of time // You perform an examination and maybe you find certain things that you are unable to refute, concerning backs, depressions and such like, it's extremely difficult. There's nothing, no investigations or tests or the like that can verify whether it actually is the way the patient describes it. And how long should sickness certification be continued before it's time to set a stop, I find it very hard."

"So this sickness certification situation just about makes me explode, when I feel like I'm a part of the system. And that doesn't mean that I don't see the individuals // for whom it (sickness certification) has probably actually been a lifesaver. That makes me wonder if there may be others who use this as an easy way out, which means that the ones that we see hardly dare to (ask for certification). But that's just a thought, it's not my definite opinion. I just feel like I'm going crazy."

#### Discussion

Problems were identified in four areas: society and the social insurance system, the organization of healthcare, the performance of other actors in the system, and the physicians' own working situation. In all areas leadership issues, such as the organization of healthcare, and existing incentives and support systems for physicians' handling of patients' sickness certification were identified as problems. Many physicians described fatigue, despair, and lack

of pride in their work, because they felt that they contributed to medicalization and prolonged periods of sick leave for patients.

As is expected when using FGDs [14] few of those invited participated. This has probably biased results in that mainly physicians who considered the topic especially interesting or problematic would have chosen to participate. However, this can be seen as an advantage, since our objective was not to gain knowledge on frequency of problems, but to identify as many problems as possible. Despite limitations, it is suggested that FGDs are superior to individual interviews since they can provide more aspects and more accurate descriptions of an issue, and limit the interviewer effect [14,19]. To assure optimal conditions for interactions in the FGDs, psychologists professionally trained in group communication acted as facilitators [14].

The validity of the results is supported by the fact that the authors have different professional backgrounds (public health, social work, psychology, and healthcare management), three also with long experience of clinical work. Inter-judge validity in analyses was high.

Our results support the findings from previous studies on various aspects of problems in sickness certification practice [4,6–10,12,20]. They agree with those reported by Hussey et al. [4] indicating that GPs feel that the sickness certification system fails to address “complex, chronic, or doubtful cases” and that patients’ behaviour and demands are problematic for the physicians to handle [4,7,10,11,21]. Problems in communication with social insurance offices have been identified [4,7,12], and also the fact that physicians find it complicated to deal with sickness certification of patients suffering from physical or mental disorders that are difficult to diagnose [5,7,10,11,20]. Previous studies have also identified problems related to physicians’ different roles as medical professionals [6,11], the lack of advice and counselling [11], inadequate instruments assessing work ability [7,10], insufficient knowledge regarding consequences of sickness absence [7], medicalization and the risk of reinforcing sickness behaviour [9,20], and concurrently contributing to prolonged or non-optimal sickness absence [20].

Besides this, we identified two aspects not previously mentioned in studies: the role of leadership and managerial responsibility with regard to sickness certification issues and the perception that the well-being of physicians can also affect the way these professionals handle certification tasks.

Several of the problems identified seem to involve tasks that are only partly related to the medical profession. Many physicians described a lack of competence in handling sickness certification issues,

particularly for patients with physical or mental pain where the symptoms were difficult to diagnose. They also described a lack of support and advice in working with those patients. This is alarming, considering the recent large increase in Western countries in sickness absence due to these symptoms [22,23]. Further work is needed to elucidate how leadership and management of healthcare affect sickness certification practice. In management research, a lack of leadership has long been considered a risk factor for both the performance and the welfare of employees [24–26].

Many of the problems described by the physicians here and in previous studies cannot be handled solely by the training of physicians, which has previously been the main strategy. They should also be addressed on managerial levels within healthcare. Further research is needed on leadership and management of sickness certification issues, on how physicians cope with problems they experience, and on what consequences those difficulties have, for both physicians and patients. Failure to recognize the complexity of the problems in sickness certification might result in interventions that will not solve the problems.

## Contributors

MvK and LS collected the data, and all four authors were involved in the design of the study, analysis and interpretation of the data, and drafting and reviewing of the manuscript. KA is the guarantor.

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## Ethical approval

The study was approved by the Regional Ethical Review Board of Stockholm, Sweden.

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