

Short-term sick leave certification for minor illness in the outpatient setting

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ABSTRACT

Introduction: Sick leave is one of the key concepts of social health protection defined by various International Labour Organisations. However it has repercussions to the economy with lost man-hours and productivity if abused. In Brunei Darussalam, sick leave are certified and issued by both government and private doctors wherein general practitioners (GPs) make-up the majority of prescribers. However with a virtually free healthcare and continuing presence of 'Flu clinic', this has put considerable strain and unwanted pressure especially on government GPs. **Materials and Methods:** Using a self-designed questionnaire for both patients and GPs, 371 patients and all GPs from two health centres were included over a study period of two weeks. **Results:** Of the 371 patients studied, 310 patients needed sick leave but only 87 patients actually warranted sick leave based on their medical condition. 188 patients (50.7%) requested for two-day sick leave but only nine patients (2.4%) were actually given two days sick leave. Majority of patients were prescribed only one-day sick leave regardless of diagnosis of minor illnesses. Sick leave was more likely to be given to patients with low education level, unskilled jobs, low salary and patients doing 'office hour' work. Peak days of sick certification were Monday and Saturday. Most patients prefer the current sick leave system and do not want a self-certification system. **Conclusion:** This study showed that a majority of patient did not warrant sick leave based on the GP's assessment. Despite this, a large proportion was given one-day sick leave.

Keywords: Sick leave certification, self-certification, minor illness, outpatient department

INTRODUCTION

Sick leave and more importantly 'paid' sick leave is one of the key concepts of social health protection defined by various International Labour Organisations (ILO) by focusing on providing healthcare and financial protection in case of sickness.¹ The ILO and World Health Organisation (WHO) established the Social Protection Floor initiative² whereby countries are required to provide adequate

social protection for all through basic social guarantees including universal access to essential healthcare and income support for every citizen.³ However only 21% of countries provide 100% replacement rates for wages with sick leave.⁴

Providing adequate healthcare and financial assistance and compensation for the workforce is important but equally, sick leave has its repercussions to the economy with lost man-hours and productivity.⁵ A recent survey in Malaysia reported an annual loss of RM 2.9 billion a year for employers.⁶

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In Brunei Darussalam, employees are relatively well protected with public sector and most private sector workers enjoying 100 percent remuneration rates for wages as long as sick leave is certified.⁷ All countries providing similar remuneration benefits, unwanted effects such as abuse of such benefits is inevitable. Hence developed countries such as the United Kingdom and Norway have adopted an 'honour' system where self-certification is accepted for a specified amount of time.^{8,9} Comparably, India has "Casual leave", distinct from the annual and 'paid' sick leave.¹⁰ Casual leave of up to seven days a year is provided and can be taken up to three days in a month, and should be used for any unforeseen situations.¹⁰ It helps to reduce absenteeism with the added benefit of converting any remaining casual leave balance to annual leave at the end of the year for the employee.¹⁰

Over the years, sick leave certification has become even more contentious. Unfortunately there is no training with regards to sick leave certification, which has put considerable strain and unwanted pressure especially towards general practitioners (GPs) who issue the majority of sick leave certificates. This study assessed the situation of sick leave certification in the outpatient clinic setting in Brunei Darussalam.

MATERIALS AND METHODS

The study was done over a period of two weeks in the Sungai Asam Health Centre and Ong Sum Ping Health Centre. Written consent was gained from all participants and permission was also granted from the Director General of Health Services to perform this research study. Ethic approval was obtained from the PAPRSB Institute of Health Sciences, Universiti Brunei Darussalam Ethic Committee.

A self-designed questionnaire both for patients and GPs was used. The questions in

the questionnaire were checked and adjusted to improve to make them simple and easy to understand. A pre-designed or previously validated questionnaire was not used for the study because a validated questionnaire from another country may not be applicable to Brunei due to different socioeconomic and cultural factors, employment structures in public and private sectors, labour laws and organisation of healthcare. Also, there are no studies that have looked at both patients and GPs concurrently on presentation.

The study included all patients attending the Flu and general outpatient clinics seen during the period using purposive sampling method. All GPs working during the study were invited to take part for convenience.

The inclusion criteria were age over 18 years; employed with a presenting complaint of upper respiratory tract infections (URTI (J00-J06)), lower respiratory tract infections (LRTI (J22)), non-infective diarrhoea and vomiting (K52), headache (G43-G44), muscular pain (M54.5, M79.1). International disease coding with ICD-10 and an international definition for skilled, semi-skilled and unskilled worker was used.¹¹ Exclusion criteria were patients currently on maternity leave or annual leave and patients who cannot read or/and write.

On registration, patients were asked their current employment status and if they were on annual or maternity leave. A patient questionnaire was given once the inclusion criteria were fulfilled. On agreement, a consent form was signed and the questionnaire filled out in the waiting area and returned to the triage nurse before consultation. The triage nurses were also responsible to enter the patient's 'queue number' on each questionnaire.

The self-administered Patient questionnaire is a four-part questionnaire divided

over two pages. The first part inquired on patient demographics, the second part on the employment details, the third on patients' perceptions towards their illness and the final part explored their opinions regarding the current sick leave system and a self-certified sick leave system.

The GP questionnaire was a separate questionnaire designed to explore the GP's perspective when prescribing sick leave for the corresponding patient. The questionnaires were filled-in at the end of the consultation. This was then matched using the 'queue number' written on both GP and patient questionnaires, and analysed.

All data were coded and entered into the Windows Microsoft Excel for Mac 2011 (Version 14.0.0) and was later entered into the IBM Statistical Package for Social Sciences Results IBM (SPSS Version 20) for statistical analysis. Chi-squared test was used where appropriate and level of significance was taken as p value of less than 0.05.

RESULTS

A total of 371 patients were included in the study over two weeks study period.

Patient's perception of their illness against GP's perception of patient illness: A total of 280 (75.5%) of patients did not warrant sick leave based on the GPs perception, yet 224 (80.0%) were given sick leave. Conversely, 91 patients (24.5%) were found to warrant sick leave and were rightly given with the exception of four patients ($n=4/91$, 4.4%) who declined sick leave (Table 1).

Overall, 96.3% ($n=310/322$) of patients who perceived their illnesses warranted sick leave were given sick leave (Table 2). One patient (2%) who did not expect any sick leave was given sick leave.

Table 1: GP's Perception (Patients that warranted sick leave).

Sick leave warranted	Sick leave given n (%)	Sick leave not given n (%)	Total n (%)
Yes	87 (95.6)	4 (4.4)	91 (100)
No	224 (80.0)	56 (20.0)	280 (100)
Total	311 (83.8)	60 (16.2)	371 (100)

Table 3 shows that number of days sick leave given against patients' perceptions. Based on patients' perceptions, majority perceived that they need two days or more sick leave (71.4%). Majority were given one day sick leave with equal portion either given two days sick leave and not given at all.

Analysis of patient factors that lead to sick leave certification: Between the gender, more female patients were given sick leave but this was not statistically significant ($p=0.57$). There were also a higher number of married patients seen ($n=232$) from which 184 patients (79.3%) were given sick leave. However being single was associated with more likely to be given sick leave compared to those married or divorced ($p=0.04$ for trend). This were also significant trends seen with regards to number of children, although there was no definite pattern (i.e. more children vs. fewer or no children), educational levels (lower among higher graduate educations), labour skills (lower among skilled labours), employment sectors (higher among the private sector), types of duty (higher among shift works), and salary scale (higher

Table 2: Patient's Expectation (Patients needing sick leave).

Sick leave warranted	Sick leave given n (%)	Sick leave not given n (%)	Total n (%)
Yes	310 (96.3)	12 (3.7)	322 (100)
No	1 (2.0)	48 (98.0)	49 (100)
Total	311 (83.8)	60 (16.2)	371 (100)

Table 3: Patient's Expectation (Days requested vs. Actual days given).

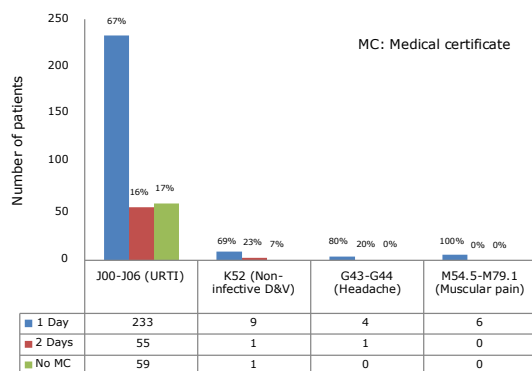
Days Needed/ requested	1 n (%)	2 n (%)	3 n (%)	>3 n (%)	Not needed n (%)	Total n (%)
1 Day given	94 (25.3)	143 (38.5)	14 (3.8)	0 (0.0)	1 (0.3)	252 (67.9)
2 Days given	9 (2.4)	38 (10.2)	12 (3.2)	0 (0.0)	0 (0.0)	59 (15.9)
Not given	3 (0.8)	7 (1.9)	1 (0.3)	1 (0.3)	48 (12.9)	60 (16.2)
Total	106 (28.6)	188 (50.7)	27 (7.3)	1 (0.3)	49 (13.2)	371 (100)

among those earning less than BND\$2,000 per month) (all p values <0.05) (Table 4).

Medical conditions and the corresponding amount of sick leave days: URTI was by far the most common condition encountered in this study. There were no difference between the types of illness and sick leaves given (Figure 1).

Days of weeks and association with sick leave certification: The largest number of sick leave given was on Monday, followed by Saturday and Tuesday (Figure 2). Friday has the least amount of sick leave. However statistical analysis (Table 5) did not show any significant associations between the days and the likelihood of getting sick leave ($p=0.84$).

Patient's opinions on current system and an alternative self-certified sick leave system: An overwhelming 308 patients (83%) did not want to change the current sick

**Fig. 1: Total sick leave according to diagnoses (n=371).****Table 4: Patient factors and outcomes.**

Variable	N = 371	Sick leave given n (%)	Sick leave not given n (%)	χ^2 Statistics (dF)	P value
Gender					
Male	171	141 (82.5)	30 (17.5)	0.440 (1)	0.57
Female	200	170 (85.0)	30 (15.0)		
Marital status					
Single	131	121 (92.4)	10 (7.6)	10.997 (2)	0.04 for trend
Married	232	184 (79.3)	48 (20.7)		
Divorce	8	6 (75.0)	2 (25.0)		
Children					
0	33	28 (84.8)	5 (15.2)	21.584 (6)	0.01 for trend
1	50	34 (68.0)	16 (32.0)		
2	44	34 (77.3)	10 (22.7)		
3	36	32 (88.9)	4 (11.1)		
4	28	20 (71.4)	8 (18.6)		
>4	50	43 (86.0)	7 (14.0)		
NA	130	120 (92.3)	10 (7.7)		
Education					
< O' level	154	134 (87.0)	20 (13)	16.226 (4)	0.03 for trend
O' Level	113	95 (84.1)	18 (17.9)		
A' Level	35	34 (97.1)	1 (02.9)		
Diploma	38	27 (71.1)	11 (28.9)		
Degree or higher	31	21 (67.7)	10 (32.3)		
Occupation					
Unskilled	168	146 (86.9)	22 (13.1)	22.486 (2)	<0.01 for trend
Semi skilled	111	102 (91.9)	9 (8.1)		
Skilled	92	63 (68.5)	29 (31.5)		
Employer					
Government	194	154 (79.4)	40 (20.6)	5.929 (1)	0.015 for trend
Private	177	157 (88.7)	20 (11.3)		
Duty					
Office hours	257	208 (80.9)	49 (19.1)	5.166 (1)	0.023 for trend
Shift work	114	103 (90.4)	11 (9.6)		
Oncall					
Yes	77	67 (87.0)	10 (13.0)	0.727 (1)	0.394
No	294	244 (83.0)	50 (17.0)		
Salary (BND)					
<499	101	89 (88.1)	12 (11.9)	33.591 (3)	<0.01 for trend
500-999	138	123 (89.1)	15 (10.9)		
1000-1999	89	76 (85.4)	13 (14.6)		
>2000	43	23 (53.5)	20 (46.5)		

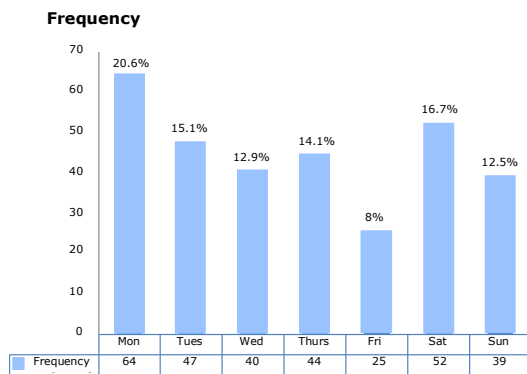


Fig. 2: Total sick leave prescribed according to days of the week (n=371).

-leave certification system but only six patients gave a reason. Among the reasons are that they preferred the current system where patients needed to be examined by a doctor before being issued any sick leave. From the 63 patients who welcomed a change, 29 preferred any system provided it is better and more efficient. Interestingly, when asked about changing to a 'Self-certification' system, the majority (94%) said 'No'.

DISCUSSION

This study showed that a majority of patient who perceived that their illnesses warranting sick leave did not warrant sick leave based on the GP's assessment. Despite this, a large proportion was given sick leave, mostly one-day sick leave. Among those who warranted sick leave based on the GPs assessments, most were appropriately given sick leave with the exception of four patients who declined any sick leave.

In our study, 86.6% of patients perceived that their illness warranted sick leave with most expecting two or more days of sick leave. It has become a worrying trend that a significant number of patients come to health centres merely to obtain sick leave certificates. In fairness, prescribing one-day sick leave is not adequate to recover from minor illness such as mechanical back pain and flu-like illnesses, nor is it sufficient to reduce the

Table 5: Analysis for days of the week and sick leave certifications.

Weekday	N = 371	Sick leave given Freq (%)	Sick leave not given Freq (%)	X ² Statistics (dF)	p value
Monday	75	64 (85.3)	11 (14.7)	2.776 (6)	0.84
Tuesday	57	47 (82.5)	10 (17.5)		
Wednesday	44	40 (90.9)	4 (9.1)		
Thursday	55	44 (80.0)	11 (20.0)		
Friday	30	25 (83.3)	5 (16.7)		
Saturday	64	52 (81.2)	12 (18.8)		
Sunday	46	39 (84.8)	7 (15.2)		

risk of infectious disease transmission in the community.

In contrast, based on the GPs assessment, 75.5% (n=280/371) of patients did not actually warrant any sick leave. Yet a large numbers were issued sick leave. Our findings highlight the trend of GPs to issuing sick leave as a "standard default" procedure in response to the mounting pressure by patients to prescribe it even when they do not think a patient warranted sick leave. This 'pressure' is a complex interlacing factors that include patient's demand and expectations, coupled with pressure from management to avoid public complaints. In addition, the increasing volume of cases being seen by GPs during both office and out of hours services are made worse with the persistent presence of the Flu-clinics. These Flu-clinics were started during 2009 H1N1 pandemic which had continued operating until today. Finally, most GPs will prefer to avoid dealing with negative issues such as conflicts when sick leave is denied.

In a study done in Scandinavia that assessed more than five thousands GPs reported several; negative issues when dealing with sick leave certifications. These issues include handling conflicts with patients over certification, assessing work ability, estimating optimal length and degree of absence, and

managing prolongation of sick leave initially certified by another physician.¹² Similar issues were reported by GPs other studies carried out in other countries.^{13,14} A more recent study in Norway and Sweden showed more than half of 4,170 GPs surveyed found sick leave certification “problematic” especially where they and their patient disagreed on the need for sick leave.¹⁵ Similar findings were reported by Foley *et al.* in Ireland.¹⁶ A follow up study by Foley *et al.*, in 2013 further explored the complexity of issues in sick leave certification, leaving GPs dissatisfied with their role in certifying sickness absence hence proposing for a policy change and development in Ireland.¹⁷ This situation have never been more significant in Brunei where pressure on GPs are further amplified with our virtually free healthcare and continuing presence of ‘Flu clinic’. Conversely, one study found that patients felt disappointed that doctors were simply ‘giving out’ sick leave and patients were not given the opportunity to discuss about their illness and to ask questions.¹⁸

Regarding patterns of sick leave, a German study reported factors such as age, gender, education level, income level, employment sector and economic and labour market developments to have a significant bearing on sick leave rates.¹⁹ The study also found that education and income levels were significant factors with scientists, lawyers and engineers with reported rates of five to seven days of sick leave in a year while for the lower income groups, the number of days ranged from 24 to 27 days. Cleaning staff and street cleaners had the highest number of days off with as much as 35 days sick leave in a year.¹⁹ Furthermore, the Workforce Institute in 2011 surveyed 9,452 people over eight countries and found that a majority of employees fictitiously called in sick when they felt they needed a day off.²⁰

In our study, patients’ factors associated with issuance of sick leaves were being

single, number of children, educational level, skill levels, employment sector, types of duties and also income levels. Some of our findings are consistent with what have been reported in the literature.¹⁹ Being single was strongly associated with being given sick leave and a probable reason maybe due to lack of family support for various reasons such as living alone or parents working or elderly parents. Educational levels, skill levels and income levels are factors that are expected to be associated with being given sick leaves and patients with these factors also more likely to perceive the need for sick leaves even with minor illnesses. Shift work schedule was also associated with getting sick leave. It has been reported that shift works may physiological and psychological effects on the human body that include disruption to biological rhythm, sleep disorders, health problems, diminished performance at work, job dissatisfaction, and social isolation. These may also lead to increase susceptibility of illness. However recent studies looking at nurses, between shift and non-shift and between those who had sleep adjusted and non-sleep adjusted did not reports on reduction in the quality of work or increase in errors, and reported viral illness. Working in the private sector was also associated with sick leave. This may be due to the differences between the two sectors; less stress and better pay in the public sector. An interesting findings despite the association between the number of children and sick leave, there was no pattern. One would expect either fewer or no children or more children to be associated with getting sick leave.

One study identified five factors that influence sick leave prescription and duration given; doctor’s knowledge of the condition, knowledge of the patient, timing of the presentation in relation to illness and recovery period, number of previous sick leave and finally, if patient “appears” to be reluctant to take time off work.²¹ Interestingly one study

found “large differences” in duration of sick leave being prescribed between physicians for “similar” type of patients.²² Therefore factors influencing and the patterns of sick certificate prescriptions differences between doctors and requires further study.

URTI was the most common illness encountered in this study. This is not unexpected given that viral illness is so common and this is universally seen in all general outpatient clinics. From our study, there was no difference seen in the patterns of sick leave request or issuance across the spectrum of conditions seen.

In our study, Monday recorded the highest number of sick leave issued followed by Saturday and Tuesday. The apparent distribution of more sick leave post-weekends can be attributed to the “Blue Monday” phenomena²³ and further emphasise the trend of the public to come to clinic in order get an extended rest. Although it can be postulated that influenza-like illness are more likely to spread during weekends due to widespread transmission in public areas and hence patients becoming symptomatic one or two days later. However, this theory does not explain for other non-communicable minor illnesses, and the high number of sick leave seen during pre-weekend days of Thursday and Saturday. If minor illness is a random event, we should see a more even spread of sick leave throughout the week.

In the last part of our study, we inquired about changes to the current system. Majority were happy with the current system and not keen to change. Unfortunately, only very few sample provided reasons as why they were not keen to change. When asked about changing to a ‘Self certification’ system which has been adopted in other countries, majority were again not keen. This may be due to the lack of knowledge or understanding the working of this system. An important

reason cited was the need of a certificate to show to employers as “proof” of their illness and hence their required time-off work. This is a very thought-provoking concept that reflects deeply on Asian cultures and its ingrained withdrawal from personal accountability and responsibility. An ‘honour’ sick leave system that *does not* require ‘proof’ from employers analogous to India’s “Casual leave”¹¹ can be considered. A proposed maximum of 10 days a year (maximum limit can be determined by separate study looking at mean sick leave prescribed over a year for patients with low socioeconomic status) and no more than three days a month of sick leave can be taken. Similar to India’s “Casual leave”, the remainder sick leave can be converted into annual leave¹¹ but in addition it can also be “cashed-in” using a staggered financial remuneration scheme. Furthermore, an extra *bonus* may be given if all 10 days are not used.

There are several limitations with our study that need to be taken in account when interpreting our study findings. Obvious limitations are the short study period and relatively small study population. The study design relied heavily upon consenting patients and resourceful triage nurses resulted in significant number of non-participation when compared to the daily clinic register.

In conclusion, our study showed that most patients did not warrant sick leave based on their doctors’ assessment. Despite this, a large proportion was given sick leave, mostly for one day. This suggests that there are other reasons for requesting sick leave other than their presenting illnesses. This suggest that most patients with minor illnesses that can be self-managed present to clinics to obtain sick leave. Given that the current system is associated with issuance of too many unwarranted sick leave, a change to a more effective system should be considered. However, these issues require further studies.

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