Issues with medical certificates

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My first locum was in a solo practice in a coalmining town, and on the Friday evening I arrived, the union man came round to the house with a bunch of papers in his hand: 'These are the compo certificates for next week Doc,' he told me. I was expected to sign them without seeing any of the men involved.

Medical certificates are an uneasy part of a doctor's practice, where the needs of patient and third party (usually employer) may be at odds. They are a frequent source of complaint.

The Medical Council's booklet *Good medical practice* says,

'Registered medical practitioners have the authority to sign a variety of documents, such as death certificates, on the assumption they will only sign statements they believe to be true. This means you must take reasonable steps to verify any statement before you sign a document. You must not sign documents if you believe them to be false or misleading, or if you are uncertain of the truth of the content'.

Prospective and retrospective

An employer complained about this prospective certificate, which turned out to be perfectly justified (the patient had medical assessments on those days): *'This is to certify that this patient consulted me on 25 March and is medically unfit for work on Saturday 6 April and Saturday 20 April.'*

But by far the most common complaint is about retrospective certification. School absences by international students breach their conditions, their visas can be revoked and they can be deported as a consequence; the pressure on a sympathetic doctor to sign a sick certificate can be considerable. In one case the administrator of an English language school complained that a student had proffered five doctor's certificates, from three different doctors, to cover absences over six weeks.

Then there is this from the owner of an export fish factory: '*We are continually having staff members off on a Friday or a Monday. Under their employment contract our employees must supply us with a medical certificate when absent on sick leave. Why is it that doctors can see a patient on a Monday and backdate a medical certificate to include time off on Friday, three days earlier? We as employers are suffering and have to pay employees two days sick leave. How can a doctor judge that a patient was sick and unable to work on a Friday when he doesn't examine him/her until three days later?*'

...and this from the headmistress of a girls' school: *'Two students who missed assessments because of absence were reminded that they were required to have medical certificates. In both cases, four to five days later, the mothers of the students visited their family doctors and obtained medical certificates retrospectively. In neither case was the student examined...'*

...and this from another employer: *'There have been recent situations when (our employee)... requested time off to attend a function with her father (declined as an inappropriate occasion and she had no legitimate leave available) she turned up with a medical certificate after she had been 'away' for the day.'*

...and from another private training institute for overseas students: *'Dr (name) has seen around 50 of my students...many students have had certificates backdated as many as 12 or 15 days, in some cases months. The time backdated just conveniently happens to cover the time they have been absent without notification and have received warning letters for.'*

Whatever our views on the propriety of employers' demanding certificates for brief work absences, or for conditions like the flu that do not need medical attention, or on whether people should come to the doctor at the start of their self-limiting infectious disease, or on rules for international students, we do have obligations. The NZMA provides guidelines on retrospective medical certificates (2000 – see Box 1), and the Medical Council has a general guideline on medical certification (2003 – see Box 2, and for the full text go to http://www.mcnz.org.nz/about/forms/certificationguide.pdf).

Is it ACC?

A trade union representative complained to the Council,

'...members we represent have been denied access to the ACC system by their GP refusing to complete ACC45 forms... In recent times, in particular with regard to an impetigo

outbreak at (factory) certain GPs have refused to give a written explanation as to why they would not complete the ACC45 form... We usually are able to convince the doctor concerned that they should at least complete the form – and let ACC decide whether or not to accept the claim.'

She went on to complain about a particular doctor who was unable to be convinced. The doctor responded that the patient was suffering from an illness and not an injury, and that he would not attach his signature to an ACC form that misrepresented that illness as an injury. He acted entirely correctly (though bravely): the diagnosis is a professional judgement for the doctor, and he would have been wrong to sign a document he believed to be false and misleading.

Box 1. New Zealand Medical Association Retrospective Medical Certificates

1. Issuing a retrospective medical certificate is inadvisable and should be done only if the doctor can be confident that the illness commenced at the time stated on the certificate. The date when the certificate is issued should be clearly stated (ie not just the date of the illness), and should always be the date on which the patient is seen.
2. A doctor may be confident of such an earlier commencement of the disease, if the signs and symptoms and state of the disease process indicate that the disease would be of a duration consistent with an earlier nominated date.
3. The medical certificate should indicate the evidence on which the certificate is based – ie the doctor's examination or the patient's statement.
4. In situations when the patient presents fully recovered asking for a certificate to cover a recent minor illness, the doctor should either decline to give such a certificate or make it clear that the certificate is based solely on the patient's uncorroborated history.
5. Under no circumstances must a doctor give a certificate which implies observations which were not made or an examination which did not occur.

Delayed insurance reports

Insurers have complained about extraordinary delays in receiving personal medical attendant reports from some general practitioners. While the Council has no stated policy on this, unnecessary delays could reasonably be seen as failing to act in the best interests of the patient, and could be cause for complaint. Good medical practice says, '*If you have agreed to prepare a document you should do so without unreasonable delay*'.

Dilemmas

There has been a recent call in New Zealand for psychologists, not general practitioners, to certify sickness benefit for patients with mental health problems, with the suggestion that the GP is too close to the patient to deny them what they want.

A new paper from Scotland explores the issue. Its abstract reads, *'General practitioners believed that the sickness certification system failed to address complex, chronic, or doubtful cases. They seemed to develop various operational strategies for its implementation. There appeared to be important deliberate misuse of the system by general practitioners, possibly related to conflicts about roles and incongruities in the system. The doctor-patient relationship was perceived to conflict with the current role of general practitioners in sickness certification. When making decisions about certification, the general practitioners considered a wide variety of factors. They experienced contradictory demands from other system stakeholders and felt blamed for failing to make impossible reconciliations. They clearly identified the difficulties of operating the system when there was no continuity of patient care. Many wished either to relinquish their gatekeeper role or to continue only with major changes'.*[1]

Carol McAllum studied general practitioners' attitudes to death certification in New Zealand for her Otago Master of General Practice thesis, and came to similar conclusions. Doctors were often uncertain of the cause of death, but were more interested in making an educated guess than involving the Coroner – they used favourite terms ('myocardial infarction' for sudden death, otherwise 'bronchopneumonia') – their concerns were more with the feelings of the family than with collecting data for death statistics. (During a focus group discussion on the subject, one doctor had a slip of the tongue: he referred to the certificate as '*the counterfeit*'; Dr Freud would have approved).[2] Perhaps the heat in the recent discussions about charging a fee for death certification reflects some of that concern for the family.

The authors of the Scottish study concluded, *'Policy makers need to recognise and accommodate the range and complexity of factors that influence the behaviour of general practitioners operating as gatekeepers to the sickness certification system, before making changes. Such changes are otherwise unlikely to result in improvement. Models other than the primary care gatekeeper model should be considered'.*

This is an interesting and important debate for general practice: can we be patient advocates as well as independent and objective professionals? Is this the down side of patient-centredness? In fact the ACC has already relieved NZ doctors of a good deal of the burden of certification, an action we have observed with mixed feelings. If doctors genuinely want to give up the responsibility to report about their patients to third parties in the objective way that certification requires, we ought to discuss it.

Box 2. Medical Council of New Zealand from Guideline on Medical Certification

1. Doctors must be aware that completing a certificate has implications for the patient, as well as themselves, and the agency receiving the certificate.
2. Doctors may be legally challenged and called upon in a New Zealand court to justify their clinical certification.
3. Certificates may have financial implications for the patient and the recipient through benefits, employment and compensation payments.
4. Completing a certificate may directly affect the safety and security of others. Certifying a patient to undertake work when he or she is unfit may place the patient or the patient's colleagues at risk.
5. Providing misleading or untrue information, either deliberately or negligently, is professional misconduct and may result in disciplinary action.
6. Certificates must be written legibly, minimising the use of medical terms for easy comprehension.
7. The information disclosed should be accurate and based upon clinical observation, with patient comment clearly distinguished from clinical observation.
8. Certificates should only provide the necessary information required by the receiving agency and consented to by the patient. The certificate should not include private or irrelevant information. A diagnosis does not have to be disclosed unless it has direct implications for the receiving agency.
9. Any comments on fitness to work should only be made once accurate information about the nature of the patient's work is obtained. Any duties that should not be attempted should be clearly stated in the certificate.
10. A certificate should clearly identify the examination date and the time period of treatment (if any). Retrospective certificates should be clearly identified as such.

References

1. Hussey S, Hoddinott P, Wilson P, Dowell J, Barbour R. Sickness certification system in the United Kingdom: qualitative study of views of general practitioners in Scotland. BMJ 2004; 328:88.
2. McAllum C. That's what I've got on the counterfeit: a study of the factors influencing the completion of death certificates by general practitioners. Master of General Practice thesis, University of Otago, 1998.