Ethical aspects of medical certification by general practitioners

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SUMMARY. As well as acting as personal physicians, general practitioners are often asked to provide medical certificates, enabling patients to obtain benefits. In these cases doctors may act for the state, for other institutions or individuals, or as an advocate on the patient's behalf in a dispute. The ethical basis of this activity differs from the therapeutic doctor–patient relationship. Difficulties are particularly likely to arise when doctors are called on to combine the roles of therapist and certifier. Although this is often convenient and saves money, the damage to confidentiality and to the primary therapeutic relationship which may result must be weighed against this. The limitations of such certificates should also be borne in mind. Fairness and the preservation of the therapeutic doctor–patient relationship are best served by restricting the role of the personal doctor to the provision of clearly defined factual information on which others, who may be medical or non-medical, can make the final judgement.

Keywords: medical certificates; certificates of need; social security benefits; medical ethics; doctor–patient relationship.

Introduction

DOCTORS are frequently called upon to complete forms which have little to do with improving health or relieving suffering, but certify entitlement to resources or exemption from duties or payments. Examples of the forms and certificates general practitioners in the United Kingdom are requested to complete are as follows:

Statutory

Statutory sick pay and social security sickness and invalidity benefit forms
Forms for disabled driving badges (orange badges)
Community charge exemption certificates
'Danger to life' telephone forms
Fitness to drive forms (Driver and Vehicle Licensing Centre, DVLC)
Evidence for social fund payments
Certificate of pregnancy
Certificate of expected confinement
Public service vehicle and heavy goods vehicle medical examinations
Freedom from infection certificates

Private

Private sickness certificates
Certificates in support of insurance claims
Personal medical attendant's report for life assurance purposes
Certificates of unfitness to attend court
Certificates of unfitness to attend jury service
Criminal injuries compensation board reports

The ethical issues involved in insurance reports have received extensive consideration[1,2] and new legislation has been introduced (access to medical reports act, 1988), largely because of the emergence of the acquired immune deficiency syndrome (AIDS) and general practitioners' growing interest in health education relating to lifestyles. The certification of sickness for time off work has also been discussed,[3,4] although authors have focused on empirical rather than ethical aspects. Other certificatory activities have been largely ignored, perhaps because their long history makes them so universally accepted as to be invisible.

In this paper the ethics of medical certification will be considered, concentrating on the relation of certification to personal medical services. Equally important, although less purely ethical, is the assessment of the utility of many such certificates. From the discussion of these two areas will follow some suggestions for good practice in medical certification.

Role conflict between certification and medical care

When the doctor making an assessment for a certificate is not the patient's personal physician the roles are clear. Both doctor and patient should realize that the doctor is acting on behalf of the body requiring the certificate, not for the patient. When, however, the patient's personal physician is also asked to act as certifier, this can produce a conflict of interests.

The main role of clinicians is to advise patients on the cause, prevention, therapy and prognosis of illness. The first concern of personal physicians is the interest of the individual, a priority which dates from Hippocrates.[5] Even when the fees for medical care are paid by a third party, the primary duty of the doctor is still to the patient.

The writing of a certificate involves a different relationship. The doctor is acting on behalf of the party requesting the certificate, not the patient, who becomes the object of the transaction; the person on whom the doctor is asked to give a professional judgement, rather than a participant in a two-sided relationship.

Sometimes the interests of the patient and of the third party may be similar. It is not desirable that someone susceptible to epileptic fits should hold a heavy goods vehicle licence; this is true both for society and for that person — although a driver about to lose his or her job may not see it that way. In other cases a conflict exists. Consider a patient who wants a permit to allow parking in a restricted area. It is clearly not in the interests of society that such permits should be given to those who do not fulfil the criteria as too many will then be issued, they will become worthless and traffic congestion will increase. The individual, however, would benefit from a permit, even if his or her case is rather borderline. In such a conflict the doctor has to be clear whose interests ultimately carry more weight.

Patients may request a certificate to support a cause they wish to pursue: a claim for sickness benefit, or for rehousing. Although the doctor may be acting for the body who will receive the certificate, the doctor could be seen as providing a service

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to the patient, in the same way as when writing a prescription or requesting a referral.

Even in this apparently more straightforward model, conflict may arise between benefiting the patient and the general responsibility to be truthful. Matters of medical judgement are seldom clear cut; it is rarely a choice between supporting the patient and telling a lie. Rather it is a question of how the truth can be moulded into the shape which best fits the patient's interests; a matter of fine ethical judgement.

Role confusion

When the doctor is asked to give an opinion directly by the third party, particularly in writing, then clearly the doctor is acting in the interests of that party. Conversely if a patient requests a letter of support, for example for a case for rehousing, the doctor is as much the patient's advocate as when writing a prescription. Unfortunately the situation is often not this straightforward. For example, the UK statement for statutory sick pay (forms med 3 or med 5), takes the form of advice to patients which they in turn use to support their claim. This implies that the doctor is acting on behalf of the patient. The subtlety of the argument escapes most people and the doctor is usually seen as giving permission for time off work. However, the doctor is ultimately paid by the government, which also pays sickness benefit. Doctors are contractually obliged to provide these certificates, and if they are unhappy about issuing a certificate a confidential note can be sent, without the patient's knowledge, to an independent medical assessor who will review the case. This scarcely fits with the model of the doctor acting as the patient's agent.

Third parties sometimes advise patients to ask their doctor for a certificate rather than approaching the doctor directly. Employers commonly do this for short illnesses not covered by statutory certificates, as do social security officers for claimants requesting benefits on health grounds, and local councils for those seeking rehousing on medical grounds. This produces confusion among both doctors and patients about the ethical basis of the interaction. For patients the doctor is just another element in a bureaucratic nightmare. They consult to get the necessary piece of paper, not to obtain medical advice. Doctors may not know where their loyalties lie if they have reservations about the patient's claim, but fear the doctor–patient relationship will be damaged if they refuse the certificate. Not surprisingly both doctors and patients often emerge from the encounter feeling dissatisfied, angry or uncomfortable.

An additional source of irritation and embarrassment is who should pay for the certificate. When a third party requests the certificate and agrees a fee, the situation is clear. So too when the certificate is part of the doctor's basic National Health Service contractual requirements. Although doctors may not like this reminder that in the last analysis they are the servants of the state and not of their patients, at least the position is clear. However, when a third party asks the patient to obtain a certificate the situation is much less clear. If the doctor is acting for the third party then the third party should pay; a reluctance to do so is perhaps one reason for the indirect approach. If the doctor is acting for the patient, then the patient should pay. Unfortunately it is often the most disadvantaged patients who require medical evidence and doctors feel understandably unhappy about charging the poor. The result is that the doctor often ends up charging no one.

Even when it is clear who should pay, it is not always clear how much. Recommended fees for private certificates are often intended merely to cover the cost of issuing the certificate, not of reaching the judgement which makes completion of the certificate possible. When the certificate is the only reason for a consultation the cost of the certificate should reflect that true cost.

Value of medical certificates

Many of the judgements which doctors are asked to make when completing forms are not medical, not possible, or not likely to allow the present system to work justly.

If benefits are to be offered on grounds of ill health then someone must assess applicants. While training in health may be appropriate for this, the training of a medical practitioner is not always the most suitable. Often the assessments are not medical but functional, and thus more properly the role of a nurse, a physiotherapist or an occupational therapist. That doctors are usually asked to write certificates is due more to social status than to the rational allocation of tasks.

Some of the judgements required by doctors seem not merely non-medical but impossible. What, for example, is meant by 'a serious risk to life' if a telephone is not available? One can imagine circumstances when a telephone could save life and some people are clearly more likely to face such circumstances than others. But a home telephone and ill health are only two elements in a complex situation, and it is hard to quantify the risk involved.

Justice requires that an equal standard is applied to all, so that, for example, the degree of disability required to obtain a disabled driver's badge is the same in Southend as in Southampton. This is inevitably a problem when many different people are involved in widely varying cases. It is worse where vague terms are used. What, for example, is a 'substantial disability for walking', the expression used in assessing patients for disabled driver badges in the UK? If many observers are involved in an assessment, psychological methodology shows a reliable result requires criteria to be clearly and operationally defined; for example, can the patient walk 100 metres on flat ground?

These difficulties apply equally to reports from independent medical assessors and to those from the patient's own doctor. Additional problems arise in the latter case. Doctors may be prejudiced in favour of (or more rarely, against) their own patients, and may more or less consciously interpret rules in the patients' favour rather than observe an impartial standard. Since the therapeutic role demands that doctors seek to do the best for their patients, it is hardly realistic to expect that they will suddenly change their orientation when faced with a form to complete.

The need to maintain a therapeutic relationship with the patient also impedes fair decisions. Whether a patient will accept being refused a certificate will depend on the nature and strength of this relationship, which is irrelevant to the merit of the case. Thus, doctors inevitably find it hard to be impartial.

These problems are well illustrated by a common situation — the patient with an alcohol problem. Such a patient may suffer frequent short episodes of vague illness. The patient's employer may become irritated by this, and require the employee to produce medical certificates for short illnesses. Since problems such as backache, headaches and lassitude have no objective signs even if the illness is genuine, this policy is of little use to the employer. Although the consultations which result may bring the problem to the doctor's attention, the focus of the consultation is the medical certificate. If the certificate is given then the patient's view of the problem as illness rather than addiction is validated. If the certificate is refused then the conflict diverts attention from the addiction and may damage the doctor–patient relationship irrevocably.

Suggested solutions

There is no easy answer to these problems, but there are steps which could improve the situation. The use of independent medical assessors, requests for clearly defined factual information only from personal physicians, more clarity about what ethical model is operating in each case, and a proper scepticism about the value of medical certificates would all be helpful.

An attractive solution to the ethical role conflict is the use of independent medical assessors, but this is more expensive than using personal physicians, since the assessor does not know the patient and therefore has to carry out a more lengthy assessment. This cost has to be weighed against the fairer judgements that may result.

Where an independent assessor is not warranted fairness could still be improved. Most medical decisions involve both empirical and evaluative judgement.[6,7] Although still not incontrovertible, the former are easier to quantify and less prone to personal bias than the latter. Thus, if the personal doctor's role were to provide precisely defined factual material, rather than broad generalizations including value judgements, decisions based on such information should be fairer. This would also decrease the risk of unpleasant and harmful conflicts between doctor and patient. When certificates attest to facts, then there is less argument or ethical conflict. For example, the certificate of expected confinement for maternity benefits is based on an assessment of state of gestation which properly requires the skills of a doctor or midwife. Since, however, there is no element of evaluative judgement in this assessment, conflict is rare.

The practice of a third party asking a patient to approach his or her personal physician for a certificate should cease. If third parties want a medical opinion they should either obtain it from a doctor paid by them for that purpose, or accept that patients' personal doctors are the patients' advocates, and view the doctors' comments in that light. The patient's doctor is not the right person to resolve a company's personnel problems or deal with the allocation of scarce social security resources.

Finally, many people, particularly those working in bureaucratic systems, seem to have a naive faith in the objectivity and reliability of medical judgements. This excessive faith is largely responsible for the problems discussed here. If institutions were to accept the limitations of doctors' statements, particularly those of personal physicians, and take responsibility for their own decisions, then the situation would be more straightforward for all concerned.

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