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Sickness certification

This article forms part of our 'Paperwork' series for 2011, providing information about a range of paperwork that general practitioners complete regularly. The aim of the series is to provide information on the purpose of the paperwork, and hints on how to complete it accurately. This will allow the GP to be more efficient and the patient to have an accurately completed piece of paperwork for the purpose required.

Sickness certificates are legal documents. Medical boards receive numerous complaints each year from patients, employers, insurers and other parties about the quality and accuracy of sickness certificates. General practitioners who deliberately issue a false, misleading or inaccurate certificate could face disciplinary action, or even a charge of fraud. This article provides some guidance for GPs about writing certificates certifying illness, and discusses common medicolegal issues associated with sickness certificates.

Keywords: general practice; sick leave/legislation & jurisprudence; work capacity evaluation

Case study

The patient, 20 years of age, attended the general practitioner on a Monday morning complaining of a sore throat and runny nose. She said that she had felt too unwell to go to her work as a receptionist the previous week and she needed a sickness certificate to cover the preceding week and also for the remainder of the current week. The GP performed a physical examination, which was unremarkable, and made a provisional diagnosis of a viral upper respiratory tract infection. He recommended symptomatic treatment and provided the patient with a sickness certificate for that day only.

One week later, the GP received a letter from the patient's employer asking him to verify whether or not the enclosed sickness certificate

on his letterhead was accurate. The GP noted that the enclosed certificate had been altered. The certificate stated that the patient was unfit for work for 1 month and reported that the patient was suffering from glandular fever. The GP was not sure if he should respond to the employer's letter. He was concerned that it may be a breach of the patient's confidentiality to do so.

The general practitioner contacted his medical defence organisation for advice. The medicolegal adviser informed the GP that it was not a breach of the patient's confidentiality if the GP informed the employer that the certificate was not accurate and it was not the certificate that he had issued to the patient. The GP should not provide any additional information about the patient's medical history to the employer without the consent of his patient.

Discussion

General practitioners frequently receive requests from patients for sickness certificates and, on occasion, are placed under pressure by a patient to provide the certificate that has been requested. From time-to-time, GPs may also be asked to verify whether or not a sickness certificate is bona fide. Generally the context for this type of request is a concern on the part of an employer that the sickness certificate has been altered in some way by the patient. Under no circumstances should a sickness certificate be 'backdated'; that is, the sickness certificate (or any other certificate) should always include the date on which it was actually written, regardless of the date on which the consultation occurred or the date of the patient's absence from work.

Risk management strategies

Good Medical Practice: A Code of Conduct for Doctors in Australia states that:

'The community places a great deal of trust in doctors. Consequently, doctors have been given the authority to sign a variety of documents, such as death certificates and sickness certificates, on the assumption that they will only sign statements that they know, or reasonably believe, to be true. Good medical practice involves:

- Being honest and not misleading when writing reports and certificates, and only signing documents you believe to be accurate.
- Taking reasonable steps to verify the content before you sign a report or certificate, and not omitting relevant information deliberately'.¹

The New South Wales Medical Council's Medical Certificates Policy states that doctors should consider the following points when a patient requests a sickness certificate:

- 2.1 The certificate should be legible, written on the doctor's letterhead and should not contain abbreviations or medical jargon
- 2.2 The certificate should be based on facts known to the doctor. The certificate may include information provided by the patient but any medical statements must be based upon the doctor's own observations or must indicate the factual basis of those statements
- 2.3 The certificate should:
 - (a) indicate the date on which the examination took place
 - (b) indicate the degree of incapacity of the patient (see section 2.6 below)
 - (c) indicate the date on which the doctor considers the patient is likely to be able to return to work
 - (d) be addressed to the party requiring the certificate as evidence of illness, eg. employer, insurer, magistrate
 - (e) indicate the date the certificate was written and signed
- 2.4 The certificate should only be issued in respect of an illness or injury observed by the doctor or reported by the patient and deemed to be true by the doctor

- 2.5 A certificate may be issued by a doctor subsequent to a patient taking sick leave. However, the certificate must:
 - (a) state the date the certificate was issued
 - (b) cover the period during which the doctor believes the patient would have been unfit for work
- 2.6 When issuing a sickness certificate, doctors should consider whether or not an injured or partially incapacitated patient could return to work with altered duties. Arrangements regarding altered duties are matters for negotiation between the patient and the employer
- 2.7 Patient rights to confidentiality must be respected; a diagnosis should not be included in a certificate without a patient's consent (note: certain employers, eg. state instrumentalities, insist on this information). Patients may request doctors to withhold information regarding their diagnosis. In such cases it should be made clear to the patient that the information provided on the certificate may not be sufficient to attract sick leave and that an employer has the ultimate right to accept or reject a certificate
- 2.8 Signing a false certificate may result in the doctor facing a charge of fraud. Furthermore, the issuing of a deliberately false, inaccurate or misleading certificate may lead to a complaint of unsatisfactory professional conduct or professional misconduct under the *Medical Practice Act*.²

What should I include in a sickness certificate?

The usual requirements for a certificate certifying illness are:

- name and address of the medical practitioner issuing the certificate
- name of the patient
- date on which the certificate was issued
- date(s) on which the patient is or was unfit for work
- if required, supplementary information of assistance to the employee in obtaining the appropriate leave, especially where there is a discrepancy in the period for which the certificate is issued and the date of the certificate.³

What if the patient does not want me to include certain information in the sickness certificate?

Patient rights to confidentiality must be respected and a diagnosis should only be included in the sickness certificate if the patient agrees to this. Medical practitioners, however, must not issue a false, misleading or inaccurate certificate. If it is a requirement that a diagnosis must be provided, doctors should obtain the consent of the patient to include this information in the sickness certificate. Ultimately it is between the patient and their employer to determine if the requirements for sick leave have been met and the employer has the ultimate right to grant or refuse sick leave in any particular situation.

What assessment do I need to make before completing a sickness certificate?

The certificate must be based on an adequate medical history, examination and on facts known to the doctor. The certificate may include information provided by the patient but any medical statements must be based upon the doctor's own observations or must indicate the factual basis of those statements. As noted above, the certificate should only be issued in relation to an illness or injury observed by the doctor, or reported by the patient and deemed to be true by the doctor.

Can I 'backdate' a sickness certificate to cover a period of illness before the date of the consultation?

Sickness certificates must always be dated on the day on which they were written. There may be medical conditions that enable the medical practitioner to certify that a period of illness occurred before the date of the consultation and examination. Medical practitioners need to give careful consideration to the circumstances before issuing a certificate certifying a period of illness before the date of examination, particularly in relation to patients with a minor short illness which is not demonstrable on the day of examination and add supplementary remarks, where appropriate, to explain any

discrepancy. If a medical practitioner cannot demonstrate any clinical evidence of the condition with which the patient claims to have suffered, the practitioner should consider whether or not to complete a letter of support.³

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References

1. The Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia, 2009. Available at www.medicalboard.gov.au/Codes-and-Guidelines.aspx [Accessed 13 December 2010].
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