Absenteeism Certification: The Physician's Role

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Two hundred five family physicians and 135 personnel managers were surveyed to determine the physician's role in certifying absenteeism. Fifty-four percent of the managers returned the questionnaire and indicated that the physician's certificate reduced absenteeism. Even though they expressed dissatisfaction with the certificate's content, the personnel managers usually did not request additional information. Sixty-six percent of the physicians returned questionnaires, with 80 percent reporting one or more requests for certification per week, and 41 percent feeling pressured to write unwarranted excuses. The primary factor the physicians considered when writing an excuse was whether the illness could be verified. Requests for excuses when conditions lacked objective findings produced physician feelings of reluctance, of suspicion, and of being manipulated.

The physician's certification of a patient's inability to work is a keystone in personnel management of absenteeism. Managers assume that the physician can determine who is able or not able to work. The physician, however, commonly does not know the demands of the occupation for which he is certifying the patient. In addition, many illnesses have no objective findings, and patients are often seen by the physician after they have recovered from the acute illness, presenting with a request for a postdated illness confirmation.

Many physicians dislike the role of certifying absenteeism, feeling that it may damage the physician-patient relationship. Such statements as, "Why drag in the physician as an accomplice?" and "I'm not trained to be a truant officer" are given regularly by physicians. The physician frequently experiences a conflict of interest; there is a closer allegiance to the patient as well as a desire to be fair and honest with the employer or the insurance company.

A review of medical literature of the past ten years using MEDLINE found little published on the topic of certification of short-term illness. A review of personnel and business literature revealed more articles on the topic but written neither from nor for the physician perspective. In an effort to ascertain the role of the physician's letter certifying short-term absences from work, a study was initiated at the Department of Family Medicine, Medical College of Ohio.

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METHODS

Two survey instruments were developed, one designed to be sent to family physicians and the other to company personnel officers. The physicians were asked for information about frequency of requests for medical excuses, feelings engendered by such requests, and factors considered before certifying an excuse. The personnel officers were asked about company policy regarding absences for short-term illnesses and the utility of the physician's letter.

The physician questionnaires were sent to 205 physicians in two northwestern Ohio counties. Lucas County, which includes the city of Toledo, and Wood County are adjoining counties with a combined population of 578,000 people. The physicians chosen were identified as family physicians by the Division of Continuing Medical Education of the Medical College of Ohio. The company questionnaires were mailed to 133 personnel officers in the same two Ohio counties. The personnel officers all belonged to the Toledo Personnel Management Association, a professional association for personnel managers. When more than one company officer belonged to the organization, the questionnaire was sent to the most senior officer only.

Each questionnaire was mailed along with a postage-paid return envelope and a postage-paid postcard that included the name and address of the person receiving the questionnaire. The physicians and the personnel officers were asked to mail the postcards separately when returning the questionnaires. This step permitted monitoring the response while maintaining anonymity of the respondents. The first mailing produced a response of 42 percent of the 205 physicians and 46 percent of the 133 personnel managers. A second questionnaire, mailed to

those individuals who did not return the postcard within three months, increased the response rate to 66 percent and 54 percent, respectively.

RESULTS

The 72 personnel officers worked in companies with a median of 437 employees (range was 2 to 8,700). Eighty-four percent of the officers indicated that the company paid sick days for their employees, and 80 percent of them required a physician's written excuse for sick time. Only 26 percent of the companies indicated they provide compensation to employees for unused accumulated sick time. The amount of time absent before a physician's letter was necessary varied from one to 30 days with a median of three days.

The personnel officers, however, were not particularly satisfied with the written excuses received. None reported they were "very satisfied," 24 percent were "satisfied," 60 percent were only "somewhat satisfied," and 16 percent were "not satisfied at all." Yet, the majority of personnel officers discussed the excuse with the physician less than 5 percent of the time (Figure 1). Responding to "Do you feel that a requirement for a note from a physician decreases absenteeism?" 17 percent stated definitely yes, 32 percent stated yes, 13 percent were uncertain, 27 percent stated no, and 11 percent stated definitely no.

The 135 physicians responding to the survey ranged in age from 28 to 77 years with a mean age of 52 years. Fifty-two percent of the physicians were in solo practice, 15 percent in partnerships, 31 percent in group practice, and 2 percent practiced in a multispecialty group or health maintenance organization.

Physicians were frequently asked to write excuses for patients; 25 percent reported one or more requests per day, 35 percent two or three requests a week, 20 percent one request per week, and 20 percent fewer than one request a week. When asked how they felt about writing an excuse when the patient had no objective findings, such as with headache or gastrointestinal upset, the physicians most often identified reluctance, suspicion, and the feeling of being manipulated. Feelings of understanding, empathy, and being helpful were reported less frequently (Figure 2). Physicians who selected "other" indicated their feelings were either neutral or highly dependent on the individual case. In addition, 41 percent of the physicians felt that they were pressured by patients to write unwarranted medical excuses. They also indicated that the employer or company physician rarely called to verify the written excuse, with 20 percent stating never, 56 percent rarely, 20 percent occasionally, and 4 percent frequently.

The physicians were also asked to select and rank five factors that they believed were most important to consider before writing a medical excuse (Table 1). The five most important factors were (1) whether the patient's complaints could be verified, (2) the length of time they knew the patient, (3) the timing of the request (whether during or after the illness), (4) the number of times the patient had previously requested an excuse, and (5) the personality of the patient.

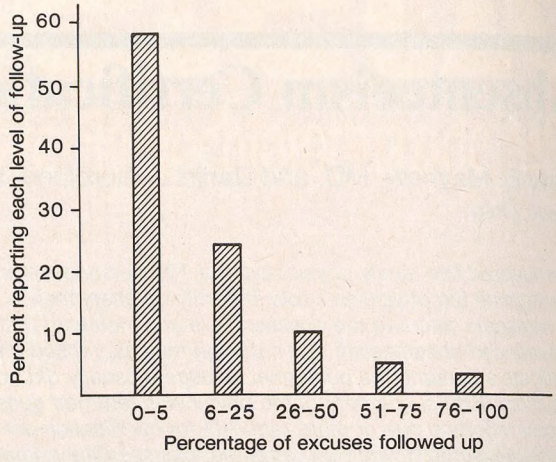

Figure 1. Percentage of excuses followed up with employee's physician by personnel officers

DISCUSSION

Absenteeism may result from many conditions such as illness, personal or family problems, or a form of withdrawal behavior with the "I did not feel well" serving as a coping mechanism.[1] While there is no unifying theory regarding attendance, the following factors are cited as strong predictors of improved attendance: personal challenge, appropriate rewards, safe environment, participation in decisions, match between assigned job and individual's goals and capacity, ability to identify with the end product, favorable attitude toward management, smaller group size, variety of tasks on the job, and absence of personal, family, and substance abuse problems.

Little is known about reasonable attendance for various kinds of work. In the past, employers frequently felt that an acceptable level of discomfort was "sick enough to visit the physician." This principle may no longer be a valid financial deterrent as more patients enroll in prepaid health care systems. In addition, many illnesses lack objective findings, and the physician frequently can neither confirm nor deny the presence of disease. The patient often makes the decision to be off work, then asks the physician to agree with that decision.

Originally, the sickness certification system was intended to regulate both absence from work and the safety of the workplace. Safety regulation has become the func-

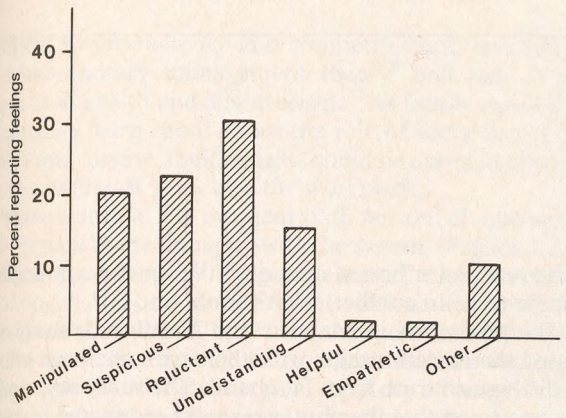

Figure 2. Percentage of physicians who report that a specific feeling is usually present when asked to certify an absence for a patient who has no objective findings

tion of state and federal agencies. Today there is a changing pattern of the kind of diseases that cause absenteeism,[2] with musculoskeletal problems, low back pain, upper respiratory tract infections, headaches, and nervous tension leading the list. These conditions frequently lack significant findings and do not permit an objective determination of the impairment.

The present system has drawn personal physicians into the role of policing their patients for management, an arrangement that frequently results in a role conflict because the physician by inclination and training serves as an advocate for the patient. As noted in this study, physicians responded to a request for certification of an illness that had no objective findings with feelings of reluctance, suspicion, and being manipulated. When objective findings are absent or when the patient has recovered from the illness at the time of the consultation, it is impossible for the physician to determine with certainty the presence of an illness.

Physicians have never officially questioned their absentee-certification function. The notes have become highly routinized with the format often being only a statement that the patient may return to work on a certain date written on a prescription blank. Even though the personnel managers surveyed in the study expressed dissatisfaction with the content of the medical excuse, there has been no significant change in the certification system. Different systems have been implemented in Europe with varying success.[3] Although the Dutch have an assigned physician evaluate employees' illnesses and do not accept personal physicians' reports, they have the highest absenteeism rate in Europe. For the first week away from work, the Swedes have a self-declaration form and are not required to have a physician's letter. Communist countries tend to use the company physician to certify absenteeism.

TABLE 1. PHYSICIANS' RANKINGS OF THE FIVE MOST IMPORTANT FACTORS TO CONSIDER BEFORE WRITING A MEDICAL EXCUSE

Factor	Percent of Physicians Ranking Factor	Average Rank*
Whether the patient's complaints can be verified	79	1.9
Number of times the patient has previously requested a written excuse	78	3.1
How long physician has known the patient	75	2.5
Excuse requested during or after the stated illness	67	2.7
Personality of the patient (ie, demanding, pleasant, manipulating, dependent)	58	3.8
Employer's policies regarding medical excuses	30	3.9
Financial needs of the patient	15	4.0
Whether the patient is responsible for children at home	13	4.0
Fear the patient will leave the practice	7	4.0
Physician's relationship with the patient's employer	4	3.0
Age of patient	4	4.6
Sex of patient	2	3.7
Marital status of patient	1	5.0

** On a scale from 1 to 5, with 1 = most important*

Since World War II there has been a change in the pattern of absenteeism.[4] The frequency of absenteeism has increased, but there has been a concomitant decrease in the duration of absences. These findings may represent a change in both the threshold of acceptable level of discomfort and the definition of illness. It may also represent a response to the more liberal benefits programs now available.

With the increased number of absences of short duration that frequently do not have objective findings, it may no longer be appropriate for the personal physician to supply an excuse for short-term illness. It is time for employers, employees, and physicians to reevaluate the present absenteeism-certification system. An efficient program is needed that not only protects the sick or disabled, but promotes good attendance as well.

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Commentary

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In an attempt to provide a taxonomy of patient behavior, McWhinney[1] offered five reasons for physician-patient contacts: the patient has reached the limit of tolerance for symptoms, the symptoms produce unacceptable anxiety, there is a problem of living presenting as a symptom, the patient wants preventive care, and the patient needs the physician's attention for administrative purposes. The last category, although barely discussed by McWhinney, is an important part of the family physician's work. Medical certifications are ubiquitous. Apart from validating an absence from work, a medical excuse can help one avoid high school gym classes, jury duty, termination of utility service for nonpayment, or, in certain circumstances, criminal liability for one's actions. For that matter, much of what passes for preventive medicine in the physician's office is administratively motivated. Examinations required as a condition of employment, eligibility for life insurance, and participation in school sports are examples of physician-patient encounters that are mandated by third parties.

Making the primary care physician a gatekeeper is a popular cost-containment strategy, and more training in this role for family physicians has been advocated.[2] Issuing or not issuing the medical certificate is another kind of gatekeeping. Yet as Mayhew and Nordlund note in the preceding paper, little is known about this aspect of the role medicine plays in the administration of contemporary society.

Every administrative use of medicine raises important ethical issues.[3] Among the most significant is the question of loyalty. Consider this scene, obviously familiar to Mayhew and Nordlund's respondents: a physician receives a call from a patient requesting a medical excuse from work. The illness has resolved. If the excuse is not provided, the patient will suffer adverse consequences at the workplace. In this setting, to whom does the physician owe allegiance—the patient, the employer, or "truth" itself? By what standard should the physician decide whether to write the note? Authoritative guidance is scarce and confusing. Industry blithely suggests there is no problem as long as private practitioners and company medical departments adopt a spirit of cooperation.[4] An occupational medicine code of ethics requires the physician to "accord highest priority to the health and safety of the individual" while simultaneously practicing "with objectivity and integrity" and only making statements that reflect one's "observations or honest opinion."[5] When these principles appear to be in conflict, what should one do?

The physicians in Mayhew and Nordlund's study assessed their relationships with their patients in an effort to distinguish truth from falsehood. The study says nothing to suggest that the physicians were motivated by positive feelings toward employers or concerned about corporate profits. They simply appeared unwilling to lie and behaved as though allegiance to truth itself was their highest value. Is this always the best choice? Truth telling in general should be preferred, but only absolutists believe that lying can never be justified, regardless of the circumstances. Whether a lie is justifiable probably depends in part on an assessment of the consequences of the falsehood.[6] It has been suggested, for example, that actively lying on behalf of a patient's claim for disability can in some cases produce a better outcome than telling the truth.[7] Would family physicians in Northwest Ohio feel more comfortable asserting falsehoods if their patients would be severely hurt by the truth?

Mayhew and Nordlund's respondents had the right instincts. They looked to their relationships with their patients for guidance on vexing moral questions. In family medicine especially, focused as physicians are on the patient rather than on the illness, they need to know much more about how this relationship can take into account the existential condition of the patient, the physician's need for integrity, and the reality of moral ambiguity.[8] As does all good exploratory research, the present study raises many tantalizing questions that should be addressed in the future. What is the epidemiology, for example, of the request for absenteeism certification? How many actually are requested after the alleged illness has resolved? What becomes of the physician-patient relationship when the request is granted, and does it matter whether the request is granted grudgingly?

From the perspective of the physician, then, the absenteeism certificate poses a moral problem. What of the personnel managers? They required medical excuses with which they were dissatisfied, yet they rarely talked to the physicians who wrote them. One half believed a policy of requiring excuses reduced absenteeism. Although the managers were unhappy, their needs were being met. Their responses show that medical certification of absenteeism is a form of control by management over a work force presumed to be untrustworthy. Such an attitude is

inimical to productivity and competitiveness according to contemporary management theory[9] and may itself produce ill health and absenteeism.[10] As family medicine researchers learn more about the role of social forces in health and disease, their insights could be useful in changing the nature of work and the workplace.

Nonetheless, at the moment both personnel managers and physicians are unhappy with the system. (Presumably, patients are happy if they get their medical excuse and unhappy if they do not.) Several reforms are possible. Physicians could certify only what they personally observe. Thus a medical certificate for an illness that has resolved might state that the patient gave a history of being ill for a certain interval and that no examination was performed, or that an examination has now been performed and the patient found free of disease and able to return to work. This solution resolves the physician's moral problem, fails to assure managerial control, and is somewhat costly if a return-to-work examination is required. Another possibility is for management to require workers taking sick time to be examined by physicians during the illness. This solution forcibly asserts control and solves the physician's ethical dilemma (since no one would validly be certified unless seen), but it drives medical care costs up, increases workers' resentment, and fills the physician's office with patients suffering self-limited illnesses that rarely benefit from medical intervention.

The best solution may be for physicians, labor, and management to agree that there are some conditions disabling enough to justify sick time but unlikely to be affected by medical intervention—upper respiratory tract infections, influenza, and the like. Given such an illness, workers could recuperate at home for a defined period without the need for a physician's excuse. This option relieves the physician's dilemma, avoids filling the office with patients who would get better on their own, keeps medical costs down, and is consistent with current managerial theory.

In all of this, it is worth remembering that well-meaning physicians contribute to the absenteeism problem. The act of diagnosing hypertension, for example, increases time lost from work independent of other factors.[11] "Do no harm" remains an important medical maxim as well as an admonition to be humble.[12]

Thus a commonplace event—a patient asking a physician for a medical excuse from work—evokes questions of ethics, primary care research, and health policy. Family medicine as a discipline begins with the premise that a biopsychosocial approach can best unravel the phenomena of everyday medical life. As McWhinney noted, our failure to apply the behavioral and social sciences to medicine is partly the result of our lack of a useful taxonomy of patient behavior. Mayhew and Nordlund have helped confirm the wisdom of that observation.

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