

Subjectivity in certification of sick leave

People who approach the health services to request sick leave often suffer from unspecific health complaints that have complex causes. The National Insurance Service’s regulations clearly stipulate that a reduced ability to work should be caused by disease or injury. Medical assessments related to social insurance claims take place at the confluence of the patient’s subjective perceptions and the doctor’s objective medical assessments. The purpose of this chronicle is to highlight an obvious incongruity between the legal basis and the practices for granting sick leave, in which the doctor’s subjectivity is rarely discussed.

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Guidelines are required to determine who will be entitled to wage compensation when individuals are unable to carry out their work. A reduced ability to work may be influenced by the health of the individual in question, but is also related to the interplay with his/her environment and the demands the employee is facing at work. However, the rules that regulate sick leave and other national insurance benefits are based on the requirement that the reduced functional ability should be caused by disease or injury (1). The doctor is responsible for certifying that the medical requirements have been complied with.

In the role of medical expert, the doctor should seek to maintain his/her objectivity and impartiality to the greatest possible extent (2). This ideal of objectivity is based on a traditional notion of disease derived from the natural sciences, in which disease is a measurable phenomenon. Even though there is widespread agreement that reduced functional capacity is based on a complex set of causal factors, national insurance legislation appears to have an exaggerated faith in the capability of the health services to determine whether the reduction in functional ability is caused by an objective disease. This kind of natural-science approach is inadequate as an explanatory model for unspecific health complaints with complex causes. This represents a problem, since unspecific health complaints with no observable pathologies or objective find-

ings tend to be characteristic of those on long-term sick leave (3). In the practical determination of whether or not sick leave should be granted, the patient’s perceptions represent the subjective and the doctor’s assessments the objective element. The doctor must exercise professional discretionary judgement, which may imply various forms of subjective assessment (4, 5).

The purpose of this chronicle is to discuss how concepts of objectivity and subjectivity are taken into account when sick leave is considered, and how these relate to professional discretionary judgement. The discussion will be based on the regulations pertaining to sickness benefit in Section 8 of The National Insurance Act (1), but the main points in the discussion are equally applicable to other forms of health-related benefits. I also wish to elucidate the practices related to sick leave seen in relation to diagnostic classification systems and how the notion of disease is understood.

Objectivity and subjectivity

Solli has operationalized various concepts of objectivity and subjectivity that are used in national insurance medicine (4) (tab. 1). Objectivity and subjectivity are studied ontologically (the theory of what exists)

and epistemologically (knowledge theory) (4). Four concepts that emerge from the table can be exemplified medically as follows: Ontological objectivity is based on a traditional approach derived from the natural sciences. According to this approach, diseases leave discernible traces in the sick person’s body. Ontological subjectivity describes matters that exist only in the human consciousness, such as the perception of pain. The requirement that a health complaint must comply with certain criteria to satisfy a specific diagnosis is an example of an application of epistemological objectivity. When the doctor undertakes assessments of a non-medical nature in his/her decisions related to sick leave, these can be described as epistemologically subjective.

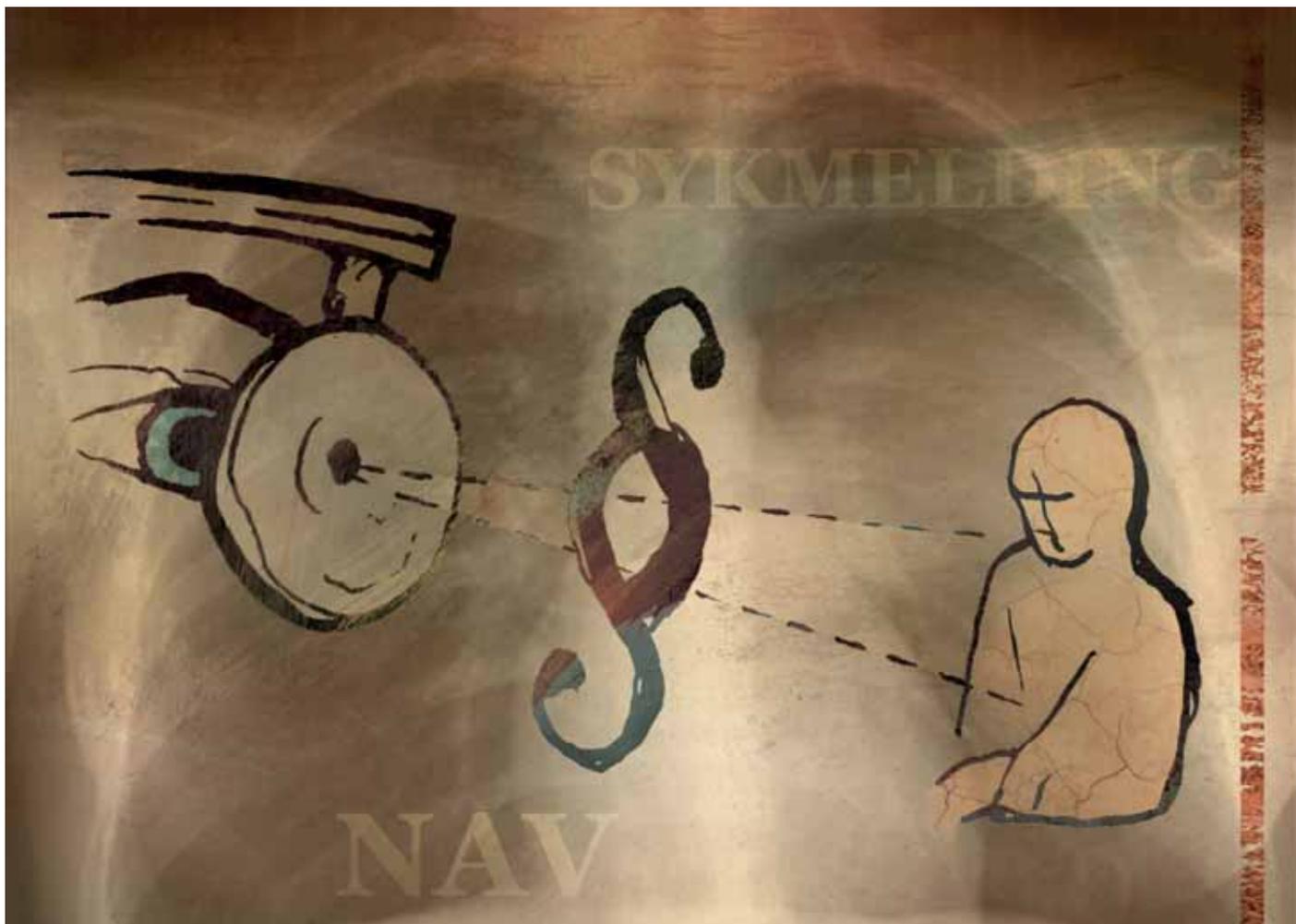
Practices related to sick leave

The National Insurance Act

Incapacity for work alone is not sufficient to give entitlement to sick leave benefit. Section 8-4 of The National Insurance Act clearly states that the assessment of incapacity for work must be based on a reduced functional capacity that is caused by a disease or an injury (1). Incapacity for work which is caused by life problems or social, financial or other problems is not grounds

Table 1 Concepts of objectivity and subjectivity in national insurance medicine [4]

	Ontological	Epistemological
Objective	<i>Ontological objectivity</i> <ul style="list-style-type: none"> • things • independent of human consciousness or knowledge 	<i>Epistemological objectivity</i> <ul style="list-style-type: none"> • factualness • impartiality • neutrality • precision • intersubjectivity • generality
Subjektive	<i>Ontological objectivity</i> <ul style="list-style-type: none"> • dependent on consciousness 	<i>Epistemological objectivity</i> <ul style="list-style-type: none"> • prejudice • bias • imprecision • arbitrariness



Drawing by Stein Løken

for an entitlement to sickness benefit. However, the boundaries between conditions caused by a difficult life situation and diseases in a medical sense may sometimes be blurred. On the one hand, a circular document from the legal sources of The National Insurance Act emphasizes that conditions associated with life problems should not be regarded as disease, and that the tendency towards a gradual liberalization of practices must be prevented by way of a more stringent application of the medical criteria (6). On the other hand, an opening is provided for the use of medical wisdom and clinical discretionary judgement, with the admission that sick leave may in some cases forestall a prolonged period of disease (6). The guidelines for national insurance medicine place a number of requirements on the doctor who fills in the sick-leave form with regard to correctness, impartiality and the use of professional discretionary judgement (2). The medical certificate should include the source of information, and the distinction between the patient's subjective symptoms and the doctor's objective findings should be clearly defined (2). It is further specified that the doctor should describe the actual

medical conditions in the form of objectively verifiable medical facts, and that these must be kept separate from the doctor's own assessments and points of view. In the medical description, it is important that the doctor acts neither as the patient's advocate, nor as the guardian of the system (2). In his/her discretionary assessments, the doctor is therefore required to refrain from letting the description become biased by his/her personal opinions of what would be the most fair or appropriate outcome (2). In the 2010 guidelines for national insurance medicine we can clearly see that the medical expert has a difficult dual role. The doctor is responsible for ensuring that the regulations are adhered to in complying with the medical requirements, while scope is provided for the exercise of discretionary judgement.

The doctor must thus ensure that the medical criteria are fulfilled, and as a main rule, sick leave should be based on an identifiable disease. But what is a disease? The response to this question depends to some extent on our perspective – as a patient, as a professional or as an administrator of public funds (7). The doctor's perspective will largely be associated with medical practice.

Knowledge of diseases comes about through attempts to identify causes and treatments for them (7). So how is sick leave granted in practice? Can the doctor in his practice rely on a notion of disease defined by national insurance legislation?

The concept of disease

Even though the concept of disease assumes a key position in national insurance legislation, the Act does not define it (6). Whether a condition is defined as a disease or not will depend on how medical science formulates the concept of disease at any given time, as well as on the practices that have developed in this field (6). In 1993, The National Insurance Court established a «consensus group on the concept of disease» to assess how well the text of the prevailing legislation functioned with regard to diffuse musculo-skeletal disorders, minor mental disorders and psychosocial problems in the context of decisions regarding disability benefit. In its main conclusion, the consensus group stated that medical science would be unable to contribute to an operative clarification of the concept of disease in terms of social benefits (8).

The diagnostic system

All certificates of sick leave must be provided with a diagnostic code. Medical causes of reduced functional capacity are coded with the aid of different coding systems in the primary and specialist health services, in which both systems have codes for disease diagnoses as well as so-called symptom diagnoses. Not all diagnoses indicate a disease in the objective sense. As a main rule, an identifiable pathology must be present in order to obtain a diagnosis. This means that the requirement for ontological objectivity has been met. Other diagnoses, so-called syndromes (9), can be said to be based on epistemological objectivity, in that certain generally valid criteria must be fulfilled in order to give a medical label to the condition. Diagnoses of symptoms, on the other hand, are based exclusively on the ontological objectivity of the patient. Not all diagnoses imply an entitlement to sickness benefit, despite giving grounds for consultation. This applies in particular to various social problems, for which the National Insurance Act has clarified the boundaries between social conditions and diseases.

The diagnostic system appears to circumvent a vague notion of disease by distinguishing between diagnoses of diseases and diagnoses of symptoms. Hence, everybody will be provided with a diagnosis code after a consultation, even though not all diagnoses will be equally valid as assessments related to national insurance medicine.

Subjectivity in the certification of sick leave

An ontologically objective notion of disease lies at the root of the national insurance legislation as well as of the diagnostic classification itself. In most cases, however, the doctor's diagnosis will be based on subjective symptoms, and not on any objective findings (8). In spite of the apparently rigid regulations, practices show that many people are granted long-term sick leave or disability on the basis of diagnoses of symptoms with no objective findings (3). How should we understand this?

The circular from the legal sources provides an opening for the use of medical wisdom and clinical discretionary judgement (6), but the guidelines strictly require that in this exercise of discretion the doctor should not be biased by personal assessments and points of view (2). Solli et al. claim that the Norwegian tradition of allowing an unencumbered and unregulated use of medical discretion could be regarded as a form of epistemological subjectivity, and call for a more qualified and less arbitrary exercise of discretionary judgement based on epistemological objectivity (10). However, it is in the nature of discretionary judgement always to include elements of arbitrariness and variation, and decision-making situations with a certain measure

of indeterminateness are implicit in professional medical practice (11).

Solli's operational definitions of various concepts of objectivity and subjectivity can serve as a useful model for describing gradual transitions from ontologically objective to ontologically subjective assessments in the doctors' exercise of discretionary judgement. As a main rule, medical discretion should be based on the medical knowledge and skills of the individual professional, although any assessments of disease and functional ability may include a non-medical element, in which the personal values and moral convictions of the doctor may be involved (5). This constitutes a significant normative problem, referred to as «the burdens of discretion» (11). Three elements in particular have a bearing on the burdens of discretion. These are the casuistic features of discretionary judgement, indeterminateness as a variation in the environment and an ever-present element of first-person experience (11). This means that the decisions made by the person exercising discretionary judgement will be influenced by his/her personal experience from similar cases, local cultural conditions and his/her personal life experiences. A study of doctors' assessments of sick leave for people suffering from unspecific health complaints confirms the wide variance in the assessments made in this context (12). Many doctors are uncomfortable with issuing a certification of sick leave when the clinical situation is incongruent with the legislative framework, and the assessments appear to be coloured by the personal experiences, attitudes and personalities of the doctors (12).

Because of the legal requirement for a medical diagnosis on social insurance certifications, we may see an unfortunate medicalization of life problems and social problems. We see that in practice, many of those who are granted sick leave are provided with an arbitrary medical label based on relatively minor health complaints, while the real reason for their reduced functional capacity is related to life problems. This lack of correspondence between the legal framework and actual practice means that the «map» does not always correspond with the «terrain». It may appear that in the practical application of sick leave, the terrain must be adapted to the map, rather than the other way round.

Conclusion

There is often a poor correspondence between the legal framework for sick leave defined by the National Insurance Service and actual practice in the health services. A number of unspecific health complaints cannot be explained with the aid of an ontological concept of objectivity. Exercise of discretionary judgement is a key element in the granting of sick leave, but this fact is

rarely discussed. There is a need for a greater degree of reflection and discussion about the subjective assessments made by doctors in matters pertaining to sick leave, including how the legal framework functions, so that the map corresponds better with the terrain.

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