Illustrative Case.—A 70-year-old man presented with haematuria. Acute urography demonstrated a large diverticulum of the bladder (Special Plate, Fig. 11), but at cystoscopy the orifice of the diverticulum could not be visualized owing to continuing haematuria from the site.

We are indebted to the radiographers, Altnagelvin Hospital, for their co-operation in carrying out these investigations. We acknowledge the help given by Mr. P. Farrell, group medical photographer.

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Self-certification for Brief Spells of Sickness Absence

P. J. TAYLOR,* B.SC., M.D., M.R.C.P., D.I.H.

Brit. med. J., 1969, **1**, 144–147

Summary: An arrangement is described for manual workers of an oil refinery to certify their own short spells of sickness absence instead of obtaining a medical certificate. No serious abuse has been found, and these spells of absence are more evenly spread throughout the week than those certified by a doctor. This system can help to reduce both the work-load of practitioners and the lost time in industry.

Introduction

The obligation to provide certificates of incapacity for work has long been a cause of complaint from the medical profession. The procedure for National Insurance certification was simplified in 1966, and an absence of up to seven days can now be covered by one form instead of two.

With the rise in national sickness absence rates (Office of Health Economics, 1968) the overall burden of certification is increasing, and, in addition, more firms are introducing sick-pay schemes which generally require a medical certificate to authorize payment (Ministry of Labour, 1964). It is becoming the practice of such firms to accept "sight" of the National Insurance certificate instead of requiring a separate piece of paper, and this can reduce the extra load of the practitioner.

The demand for certificates to cover brief spells of absence has been the main cause of objection, since most of them can only be *ipse dixit* in nature, and the B.M.A. Annual Representative Meeting in 1964 resolved that "every effort should be made to abolish the demand for medical certificates of incapacity for illness of less than three days."

Uncertificated paid sick absence for periods of up to three days has been usual in industry for staff (white collar) grades, but is still rare for manual workers (labour). A few firms have followed the example of the Civil Service, which allows "Whitley Days," but this is unlikely to be widely extended.

This paper describes the effects of introducing a signed declaration for short spells of sick absence among manual workers who had previously been required to produce a medical certificate.

Description of Certification Requirements

The company has operated a relatively generous sick-pay scheme covering all employees since 1946. Payment is made without waiting days and consists of the full normal wage after allowing for the individual's entitlement to social security benefit. While staff have always been allowed to take up to three working days on the strength of their own statement of incapacity, manual employees were required to provide a doctor's certificate.

Early in 1964, in order to obtain some form of diagnostic data for staff short-sickness absences, a "self-certificate" was introduced, which staff who had been absent were asked to complete. This arrangement was voluntary, but with explanation and encouragement a description of symptoms is now obtained for all such uncertified absences.

In June 1965 a similar scheme was introduced for the manual hourly-paid labour. Medical certificates are no longer required for sickness absences of up to three working days, but on

CONFIDENTIAL

To: 1. Time Office

2. Refinery Medical Officer,
Medical Centre.

Please fold to this line

UNCERTIFIED SICKNESS REPORT

My uncertified sickness from _____ day _____ a.m./p.m.

on ___/___/196__ to _____ day _____ a.m./p.m.

on ___/___/196__ was due to the following illness.

(Brief description of symptoms—e.g. cold, 'flu, diarrhoea, sore throat).

Date _____ Signed _____

S.P. No. _____ Department _____

FIG. 1.—Employee's self-certificate

* Senior Medical Officer, Shell U.K. Limited, Shell Haven, Stanford-le-Hope, Essex. Present address: Institute of Occupational Health, London School of Hygiene, 43 Russell Square, London W.C.1.

return the employee is asked to complete the form (Fig. 1), stating the symptoms, etc., which had caused his absence. This self-certificate is sent to the personnel record office as an authorization for sick payment and then to the medical department.

Effects of New Arrangements

The comprehensive medical and sickness absence records held in the refinery have already been described (Taylor, 1967) ; they allow various methods of analysis. The certification requirements for staff employees had not been changed, and to some extent they can be regarded as a control group. The new scheme for labour employees was introduced in June 1965, and absence records before and after this year were compared. There is a low turnover in both groups and the age structure remains substantially unchanged.

Overall Pattern of Absence

The most obvious effect of the change was, as predicted, a sharp rise in short spells, but this was associated with a reduction of absences lasting from five to eight days. Standardized for age, the labour rates in 1966 showed a rise in spells of all durations of 25% over the rate in 1964 but a fall in total time lost of 15%, while those for staff changed little.

For many years past the staff have taken over half of their absences in the form of short spells, but these had amounted to only one-third of all absences among manual workers. Since 1965 this difference has disappeared. There is no evidence that as a group the workers have abused the concession, and the distribution of absences by length of spell is now very similar to that found in staff (Figs. 2 and 3). Though more workers are taking the odd day off, a number of them avoid going to their general practitioner with minor illnesses for which they used to get a certificate for a week or so.

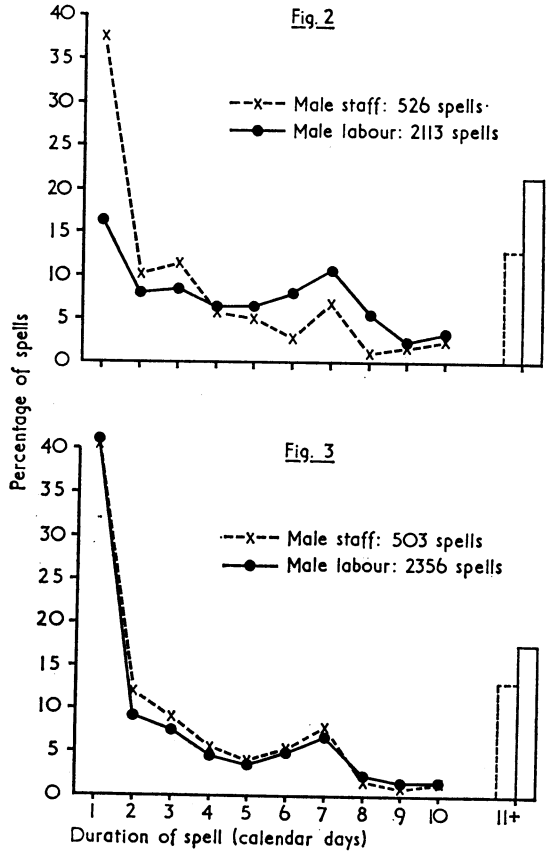

FIG. 2.—Shell Haven 1964. Proportions of sick spells by duration.

FIG. 3.—Shell Haven 1966. Proportions of sick spells by duration.

Utilization of Self-Certificates

The fact that a medical certificate is no longer required by the company for absences of one to three days has not completely removed the demand from general practitioners. This is partly due to the regulations about national insurance sickness benefit with the waiting-day rule and the 13 weeks in which spells of two or three days can accumulate. With the company sick-pay scheme making up the difference between the entitlement to State benefits and normal wages, the employee having three days off without a medical certificate when he has been sick for nine or more days in the previous three months stands to lose three days' national insurance benefit. Unfortunately the regulations also apply to another period of incapacity in the three months after the first. For this reason alone many men still obtain a certificate, and the introduction of the Earnings Related Supplement has aggravated this problem.

In 1966 the proportion of short absences for which a medical certificate was produced was higher among labour than among staff, but rose for both groups with increasing length of spell (see Table). Absences of four and five calendar days are included, since day workers, who are all on the five-day week, can start an absence on a Friday and return on a Wednesday, losing only three working days.

Short Spells for Male Staff and Labour, and Proportions Covered by a Medical Certificate in 1966

Duration of Spell (Calendar Days)	Staff		Labour	
	All Spells	Medically Certified	All Spells	Medically Certified
1	204	2%	967	15%
2	60	15%	214	40%
3	45	36%	176	50%
4	26	46%	101	75%
5	18	83%	83	91%

Day on which Absence Began

Medically certified absence most commonly starts on a Monday, except for the shift-workers whose working weeks begin on a Tuesday (morning shift) or a Friday (afternoon and night shift). The data for the two years 1966 and 1967 were combined (Fig. 4) to obtain larger samples. It is also of interest that the rates per man do not differ among day workers under or over the age of 40.

With self-certified absence, however, a different pattern appeared (Fig. 5), the younger men having about twice as many spells as their older colleagues and only the day labour under 40 showing the steep fall from Monday.

If it is reasonable to assume that minor illnesses are likely to produce incapacity for work at a more or less level rate throughout the week, this pattern is seen in shift-workers of all ages and in staff over 40 ; day labour over 40 have a much less uneven distribution than their younger colleagues.

Diagnostic Pattern of Self-Certified Absences

Acute gastrointestinal upsets and upper respiratory infections have been the commonest diagnoses for short sickness spells at the refinery for several years, and the pattern has not changed since self-certificates were introduced. There is an appreciable difference, however, in the relative position of these conditions between staff and labour. The data from 1966 and 1967 combined shows that, while respiratory infections are commonest among staff, they are relatively less so among labour, though absolute rates per man are higher in day labour (Fig. 6). If a constant daily rate suggests little abuse, this applies most to respiratory conditions in all groups of men, and least to the intestinal disorders.

Abuse of Self-Certification

After three years' experience there is no evidence that the concession has been seriously abused, and certainly no more by labour than it already had been by staff. The figures were carefully watched during periods near national holidays—for example, New Year's Day—and also during the summer holiday times, but no excess of self-certified absence was found.

A few individuals have certainly taken days off for very dubious reasons, but these have usually been quickly spotted. One man was unlucky enough to be seen on the television news sitting on the beach at a holiday resort and his self-certificate the next day for "gastro-enteritis" was not accepted. Another took six Thursdays off out of eight, half of them medically certified, until it was found that he had been doing a part-time job. These examples are, however, exceptional.

Frequent absentees are seen informally in the medical department. No previously unknown chronic disease has yet been found; only nine out of 206 men known to have chronic medical impairments used these certificates more than three times in 1966, and only two of them had organic disease.

Frequent brief spells of sickness absence are only rarely caused by serious organic disease, but are usually an indication of psychosocial problems at work or in the home. For the frustrated or disgruntled employee the onset of a relatively minor symptom can be enough for him to decide that he is unfit for work. In many such cases a change of job has resulted in a dramatic fall in absence rate.

Discussion

The different types of sick-pay scheme in current use in this country have recently been described (Rutter and Ottaway, 1967). Remarkable degrees of inequality exist within some organizations, and the view that white-collar workers can be trusted but that manual workers cannot is still widely held.

There were fears among some members of management at the refinery that this relaxation of certification requirements would be grossly abused. The sharp rise in short absences was expected, but after three years the rate has not proportionately exceeded that customary among the staff. Serious abuse has proved to be minimal though it has been looked for. The employees involved welcomed the change, since many had felt diffident about visiting their practitioner solely to obtain a certificate. One family doctor has reported that such attendances accounted for 18% of his weekly consultations (Swan, 1964), and it is likely that some patients may even embroider their symptoms to justify the consultation and thus receive a certificate for several days.

The decision that a patient is unfit for work is very seldom strictly medical, particularly when the condition is not severe, and in the great majority of cases the decision is really taken by the patient. The doctor rarely has any detailed understanding of the job, and whether or not it can be modified; the patient's estimate may often be coloured by factors other than physical

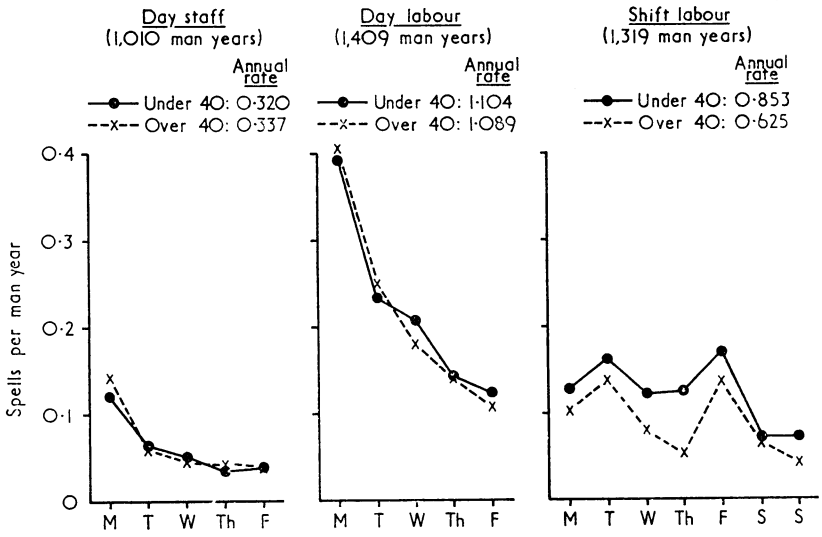

FIG. 4.—Day of week commencing absence. Shell Haven males under and over age 40 years. Medical certificates—inception rates, 1966+1967. ———, Under 40. – – –, Over 40.

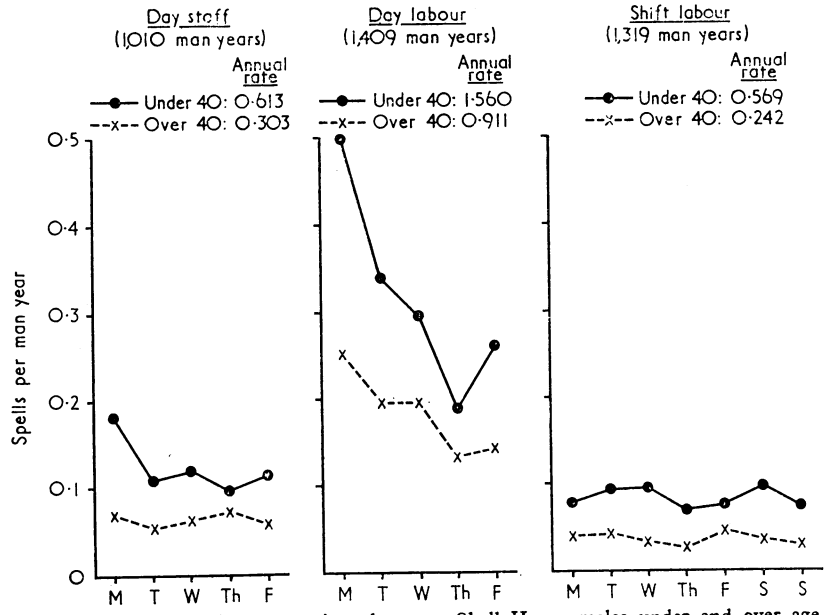

FIG. 5.—Day of work commencing absence. Shell Haven males under and over age 40 years. Self-certificates—inception rates 1966+1967. ———, Under 40. – – –, Over 40.

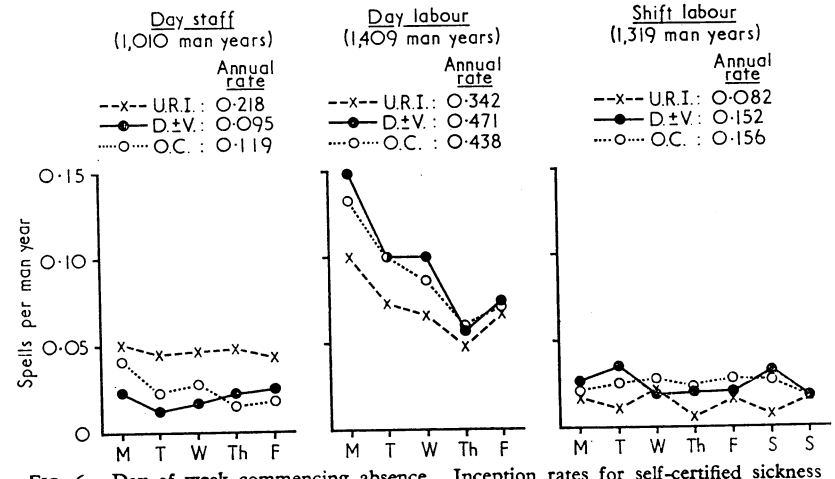

FIG. 6.—Day of week commencing absence. Inception rates for self-certified sickness 1966+1967. Upper respiratory infections X– – –X. Diarrhoea ± vomiting ●———●. Other causes (O.C.) O . . . O.

fitness. The arrangements described in this paper have merely regularized what is actually happening and also reduced the burden on the general practitioner. There may even be a case for extending these arrangements up to a week, but this would require a change in the regulations covering payment of State benefit.

The tendency to start a period of certified sickness absence on a Monday has been described before (Hill, 1929 ; Wyatt *et al.*, 1943 ; Gordon *et al.*, 1959) and at the days of shift change (Taylor, 1967). The peaks of duration of certified absence at 7, 14, and 21 days have also been described (Raffle, 1966). It is of interest that a different pattern occurs with self-certified absence, particularly in men over 40 years. The lowest rate among manual workers was found on a Thursday, which is pay day, but medically certified absence is lowest on Fridays. Both weekly patterns are more sociological than medical in nature, as is the return to work on a Monday, but with certification regulations this behaviour places a heavy load on the medical profession.

A " make-up " type of sick pay in which deductions are made for sick benefit entitlement unfortunately tends to send employees to their family doctor, since the waiting days and 13 weeks of benefit period must be recorded. It has been estimated that payment of benefit on the first day of sickness without waiting days would cost the State half as much again. However, waiting days are unusual in industrial sick-pay schemes. The suggestion that firms with such schemes could administer National Insurance benefit for their own employees would remove this anomaly, but this would involve a change in the law.

The low rate of self-certified absences among shift workers confirms the findings already reported that these men have less certified absence than day workers (Taylor, 1967). It would appear that these two groups behave in an entirely different way and that any physiological disadvantages of changing circadian rhythms are far outweighed by the advantages of higher morale and job identification found on continuous shift.

Finally, it is necessary to point out that these results relate to a company with a full-time occupational medical service, and the employees know that their sickness statements may be scrutinized by a doctor. This could be a disincentive to frivolous or unjustified declarations of sickness, and these arrangements may not be so acceptable in places without a medical service. This does not affect the suggestion that employers should treat manual workers as responsible adults.

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Sick Absence Certification. Analysis of one Group Practice in 1967

STUART CARNE,* M.B., M.R.C.G.P., D.C.H.

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Summary: Certificates of inability or fitness to work were issued on 6,161 occasions in one year in one group practice. Half the episodes of illness lasted for seven days or less, and two thirds of the episodes ended on a Sunday. Clearly in most cases the doctor does no more than countersign the patient's declaration of his fitness or not to work. Abolition of short-term medical certification would probably have little effect on absenteeism or the sums paid out as sick benefit.

Introduction

To the nation's industry sick absence certification is a major factor in loss of production. Most such certificates are issued by general practitioners, though the actual proportion is not known. The terms of service of a G.P. in the National Health Service include the duty of issuing certificates for National Insurance (N.I.) purposes to patients who need them.

Ashworth (1961, 1965) analysed the issuing of N.I. certificates in his Manchester practice for 12 months in 1955–6, and Grossmark and Sharer (1967) carried out a smaller survey over three months in 1966 in their North-west London practice. Handfield-Jones (1964) kept records in a rural practice for six weeks in 1964.

* General Practitioner, the Grove Health Centre, London W.12.

Taylor (1967a, 1967b, 1968) and Raffle (1965), representing the industrial health service, made extensive studies of sick absence in relation to the type of worker claiming benefit. Morris (1965) considered the problem from an epidemiological point of view. From time to time various Government departments publish reports, and Alderson (1967) has commented on these. The Office of Health Economics (1965) also synthesized this information to show various trends.

In 1964–5, as part of a more extensive study (Carne, 1969), it was shown that certificates were issued at 17.4% of all consultations (and at 26.2% of the consultations for patients aged 15–64). Because they constitute an important part of the day's work of a general practitioner, a further study was carried out for the whole of the year 1967 in an N.H.S. practice in West London.

The practice itself (Carne, 1961) is very mixed, 41% of its patients being immigrants. All patients are seen by appointment (Carne, 1967). There are three G.P. principals with average-size lists, and some of the patients are also seen by a trainee assistant.

During the year studied records of all sick absence certificates issued by the doctors in the practice were kept on specially designed record sheets. In this report information is presented about patients aged 15 to 64. At mid-year 1967 there were 4,397 patients in this age group on the practice register (2,276 males, 2,121 females).