

Practice Standard

Medical Certificates and Other Third-party Reports

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Related topic(s):	Independent Medical Exams ; Medical Records Documentation ; Medical Records Management

A **practice standard** reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the College of its registrants (all physicians and surgeons who practise medicine in British Columbia). Standards also reflect relevant legal requirements and are enforceable under the [Health Professions Act](#), RSBC 1996, c.183 (*HPA*) and College [Bylaws](#) under the *HPA*.

Registrants may seek guidance on these issues by contacting the College or by seeking medical legal advice from the CMPA or other entity.

PREAMBLE

This document is a standard of the Board of the College of Physician and Surgeons of British Columbia. It offers considerations that registrants must reflect upon before they provide medical certificates or reports to patients who may use these documents to obtain workplace accommodation or insurance benefits from employers or other third parties. Such requests may originate from government departments or agencies (e.g. WorkSafeBC), private non-governmental sectors such as lawyers, the Insurance Corporation of British Columbia, and other insurance and disability carriers.

This document must be read in conjunction with [*Independent Medical Examinations*](#).

COLLEGE'S POSITION

Registrants are ethically and legally obliged to provide reports on patients they have attended, even when they have not seen them for some time and are unable to provide a current report.

Registrants are frequently asked to provide medical certificates for a patient's employer or another third party such as a disability insurer. When a request has been received, the registrant is required to respond in a timely manner, with objective medical information despite pressures to advocate on behalf of the patient. The registrant is expected to differentiate between objective medical information and opinion.

Registrants must recognize that employers and their insurers will be relying on the information provided to them by the registrant in making decisions concerning financial and other entitlements.

Registrants may be subpoenaed as witnesses, required to produce clinical notes, and examined and cross-examined under oath about the information already provided by them in medical certificates or other forms.

Registrants must also be aware that if they provide misinformation, or erroneous or unfounded opinions, employers and insurers who have relied on such representations may have claims for damages against the registrant. The College may consider the provision of untruthful information or inappropriate delay in producing medical certificates or reports as professional misconduct.

STANDARDS

- Registrants must ensure that they have received the patient's valid and documented consent to provide any information to an employer or other third party. Consent must include discussion about the scope, purpose, and likely consequences of the disclosure of their personal health information and the fact that relevant information cannot be concealed or withheld.
- Because it may be difficult to confirm what information was provided to an employer or other third party in a verbal or telephone conversation, registrants are advised to avoid verbal communication unless the patient is party to that conversation.
- Statements made must be truthful and based upon objective clinical information about the patient and not simply a repetition of the patient's self-diagnosis.
- Medical information must be presented in a clear and factual manner, with opinions that are supported by objective medical evidence.
- Conjecture, speculation and inappropriate advocacy in medical certificates or reports must be avoided.

- Registrants must provide medical certificates or reports in a reasonable time frame; this is usually considered to be within 30 business days of the request but may in some situations be shorter.
- If they are unable to respond within a reasonable time frame, registrants must communicate directly with the third party and negotiate a new time frame or provide the reasons why they cannot comply.
- If a patient was not seen during a period of disability or illness, an opinion about retrospective diagnosis may be provided but the fact that the patient was not seen during that period must be clearly stated.
- Before giving an opinion on a patient's fitness to perform a specific activity or job, registrants must ensure that they have accurate information about the activity or the requirements of that job.
- Registrants must not disclose more information than is covered by the patient's consent or requested by the third party.
- Registrants must clearly specify the addressee for whom the medical certificate or report is intended.
- Fees must be discussed with the requesting third party in advance of the report preparation. Fees charged must be fair and reasonable—reflecting the work required—and consistent with the Doctors of BC *Guide to Fees* for non-insured medical services.
- Registrants may request, but they must not demand, payment in advance for their professional services. A report cannot be withheld contingent on pre-payment.
- Fee disputes between registrants and lawyers can be referred to the Medical-Legal Liaison Committee of Doctors of BC.

RESOURCES

The Canadian Medical Protective Association

- [Privacy and Confidentiality](#)
- [Medical Legal Handbook](#)