TALKING POINT

Medical evidence of incapacity

F J DARBY

Social security incapacity benefits are designed to provide cash in place of earnings for employed people who cannot work because of illness. Payment is not dependent on a means test or other evidence that income has ceased. But it does depend on medical evidence linking incapacity for work with mental or physical disorder or both. This is usually provided by the family doctor on form Med 3. The system enables some control to be given to claims, but, more importantly, allows benefits to be paid promptly and with the minimum of fuss to a patient who is ill and has been advised by his doctor to stop work.

The system does not fire doctors with enthusiasm, for—whatever its socioeconomic importance—they do not regard it as an aspect of medicine. Much absence is due to non-medical factors. The short spells, in particular, are often a consequence not of illness but of psychosocial factors associated with a particular personality and a “proneness” to incapacity. Management of this “proneness” lies more within the province of the firm’s doctor, the industrial psychologist, the personnel officer, and, above all, the works manager than the GP. Many doctors think that it is industry’s job to instil a responsible attitude to work. Indeed, the covert expression of conditions usually responsible for short-period incapacity seems to imply that it is the patient rather than the doctor who decides when he should abstain from work and when he should return. Doctors are particularly conscious of the number of attendances by short-period claimants—over half of all spells of incapacity are for 12 days or less.

Disputes between GPs and patients over incapacity and the issue of doctors’ statements are liable to occur if a GP is to provide medical evidence conscientiously. Taylor¹ suggests that those doctors who do resist certification soon tire “and there are those who will argue about a certificate once a day.” Even so, according to one survey² one-third of patients considered that their doctors did not, or sometimes did not, let them have certificates when they needed one. The Department of Health’s experience is that most doctors do not issue Med 3s “on demand.” The profession rightly puts a high value on the doctor/patient relationship and thinks that it should take precedence over duty to the National Insurance Fund. Doctors almost invariably give the patient the benefit of any doubt about the presence of symptoms; to do otherwise is tantamount to declaring him a malingerer. The mental stress of a GP when he suspects a patient is lying, but cannot prove it, should not be underestimated; he is conscious that stress would be absent if providing medical evidence were not part of his terms of service. The GP sees that, while his consultations sometimes give rise to altercations with patients, examinations by a regional medical officer that lead to the patient’s return to work rarely have repercussions in the surgery. Thus many doctors think that the provision of medical evidence of incapacity is a distasteful duty that wastes their time and impairs re-

lationships with their patients. For short-term incapacity, in particular, it makes unreasonable demands. The Annual Conference of Representatives of Local Medical Committees in 1976 resolved to ask the GMS Committee to make representations to the DHSS to free general practitioners of the obligation to provide certification of short-term sickness absence from work.

Advantages of Med 3s

So what are the arguments in favour of the present system? Both the taxpayer and the contributor to the National Insurance Fund are interested in reducing unwarranted absence from work. They see the provision of accurate and reliable evidence from a medical source as one important way of achieving that aim. About £25m a year is at stake for short periods lasting six days or less. Their interests are not the same as the doctor’s except in so far as he is also a taxpayer and contributor. Nevertheless, the medical arguments for having a system of certification are substantial.

The issuing of Med 3s by the GP ensures continuity of care by the same doctor. Advice on whether a patient should work or rest is one aspect of treatment and one which the person most familiar with the patient’s history, present condition, and motivation—the patient’s family doctor—is uniquely able to decide. The patient may gain in another fashion from having to attend the surgery for a doctor’s statement. He may attend for an apparently minor illness that would not otherwise take him there but is in fact serious. Treatment may then be started at a satisfactorily early stage. Such cases, however, are rare. The issue

of a doctor’s statement is also helpful in relieving the genuinely ill patient of financial anxiety. It provides readily available evidence of incapacity to substantiate his absence from work. Payments of benefit might be delayed and outside pressures might prove intolerable to someone who is sensitive.

Although doctors are conscious of a conflict about issuing Med 3s most patients seem satisfied. They would say they are unlikely to tell lies about symptoms and capacity for work to family doctors on whom they know they are dependent at times of medical crisis. Like doctors, they may resent attendance for disorders that would respond to self-medication, and they may similarly think that their time is being wasted. The system also seems to satisfy employers, admittedly not an argument likely to impress a doctor. Increasingly they ask to see National Insurance certificates as a check on sickness absence. Implicit in this view, as in that of the guardians of the National Insurance Fund, is that the doctor is pre-eminent in his ability to assess capacity for work.

Regional certifiers?

If the present system were discontinued what would be the alternatives? The regional medical services might be given a certifying role. At present they employ 70 medical officers in Great Britain who spend about two-thirds of their time on reference work. They are assisted with this by about 400 part-time “medical referees” from general practice. There are about 10 million new claims a year, and when a claim is first made it cannot, of course, distinguish with certainty the person

Health Services Board

Removal of diagnostic facilities for private patients

The Health Services Board will make proposals by 30 September 1978 (to take effect before 1 January 1979) to remove facilities for private outpatients and/or day patients for diagnostic pathology, diagnostic radiology (including scanning, ultrasonics, and methods using radioisotopes), and other diagnostic purposes. Under the National Health Service Act 1977 (Section 66) the board has a duty to propose the progressive revocation of authorisations that permit consultants to use NHS accommodation and services for their non-resident private patients.

In a letter (7 June, 1978) to regional and area administrators and to secretaries of boards of governors the board has listed those hospitals that were not used by non-resident private patients in 1976 and 1977. The board regards the absence of use as evidence that there is a lack of reasonable demand for

facilities or that there are sufficient facilities elsewhere. The letter emphasises that the revocation proposals will not affect the availability of accommodation and facilities for private non-resident patients where these are provided otherwise than under a Section 66 authorisation—for example, under a rental agreement. The board has no power to withdraw a revocation proposal once it has been made, even if the proposal is later found to have been based on incomplete or inaccurate evidence. So consultants, whom the board has asked AHAs to consult, should ensure that the facts are known. Copies of the letter can be obtained from area administrators or from the board’s office (01-633 9216 ext 28).

Any representations or comments should be sent to the secretary of the Joint Consultants Committee, BMA House, Tavistock Square, London WC1, by Friday, 18 August.

who will prove to be a short-term claimant from a long-term claimant. To examine that number of people the Department estimates that over 2000 full-time medical officers, or their part-time equivalents, would be required to work solely on evaluation of incapacity. It would be difficult to justify diverting such a relatively large proportion of the country's medical manpower to staffing a separate medical certifying service. The employment of more part-time "referees" would similarly divert doctors from other tasks of greater medical importance.

There would also be drawbacks for the general practitioners if they forfeited responsibility for providing medical evidence. If the regional medical service took on the job the practitioner would lose an important aspect of control over his patients' treatment. How often would a GP be content to have a RMO deciding, for instance, that the patient should stay at home or should get out of bed and go to work? The traditional types of dispute between general practitioner and patient would be replaced by disputes between practitioner and examining doctor, in which the GP, having now no part in providing medical evidence of incapacity, would have a hard job getting his view accepted. There would therefore still be friction between GP and patient, who would expect his doctor's support when the examining medical officer considered him fit for work against his inclination. Experience in the Netherlands, where there is a separate corps of certifying doctors, suggests that sickness rates would increase.

Could self-certification provide a remedy, the regional medical service providing an opinion in selected cases? There would still be the problem of recruiting additional doctors of the right calibre, and an increase in lay visiting from the local insurance offices might not be an adequate substitute for medical evaluation. Although a lay visitor can see whether a claimant is behaving in a way inconsistent with incapacity for work or is seriously ill, he has to rely on patients' subjective assessments even more than doctors. When general practitioners refused to sign certificates for three weeks in June 1970 new claims for both sickness and industrial injury benefits were about 75 000 fewer than usual for the time of year. But changes in environmental circumstances, even in such things as benefit requirements, usually take time to alter patterns of group behaviour and no valid conclusions can be drawn from the 1970 experience. Experience in industry is equivocal. According to Ager,³ a system of full pay and no certification for short-time incapacity in one organisation resulted in an increase by nearly five times in absences of one to three days. Taylor¹ reported that a similar system accelerated the trend of taking more frequent spells of sick leave though for shorter periods.

A somewhat wearisome duty

Payment of money held on behalf of the public is necessarily subject to audit. If sums are paid out for sickness absence there must be a system for determining the presence or absence of incapacitating disease. A separate corps of certifying doctors would be expensive of manpower and would undesirably limit the clinician's ability to advise on his patient's activities. Despite arguments in favour of self-certification, it seems unreasonable for a person to be able to draw a cheque on the

National Insurance Fund as his disposition takes him: such a system would therefore require detailed supervision, with more lay visiting than at present and an organisation to provide medical control much larger than the existing regional medical service. More staff would be required even if general practitioners provided opinions only on long-term incapacity. Faced with the alternatives, most doctors would probably agree with the Annis Gillie Report³ that "certification for statutory purposes is . . . a somewhat wearisome duty, not part of the essential practice of medicine." Few, however, would deny that they are exceptionally well qualified as witnesses to incapacity.

The provision of medical evidence by the general practitioner has recognised disadvantages but it has greater validity than evidence from other sources and must surely remain the basis of an evaluation of a person's incapacity for work for the short as much as the longer periods. Changes may be necessary

in the present system but is there an alternative, fundamentally different, that would be as satisfactory for the patient, the doctor, the taxpayer, and the insurance contributor?

References

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- ² Marsh, G, and Kaim-Candle, P, *Team Care in General Practice*. London, Croom Helm, 1976.
- ³ Ager, J E, in *Proceedings of Symposium on Absence from Work Attributed to Sickness*, ed A Ward Gardner. London, Society of Occupational Medicine, 1968.
- ⁴ Taylor, P, in *Proceedings of Symposium on Absence from Work Attributed to Sickness*, ed A Ward Gardner. London, Society of Occupational Medicine, 1968.
- ⁵ Central Health Services Council, *The Field Work of the Family Doctor*, Report of the Subcommittee of the Standing Medical Advisory Committee. London, HMSO, 1963.

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Fees for part-time work

Who negotiates?

The following note is based on a document prepared by Dr J D J Havard, principal deputy secretary of the BMA.

Until 1974 fees for part-time services for local authorities (for example, supervision of medical establishments, reports for social services departments, etc) were negotiated in Committee C of the Medical and (Hospital) Dental Council of the General Whitley Council. The Public Health Committee of the BMA provided the staff side and the local authority associations the management side. In practice the Private Practice Committee negotiated the fees because of the relationship between these fees and the other fees which the committee had already negotiated, particularly those negotiated with the Treasury for work for government departments (now negotiated with Civil Service departments). From the 1960s the local authority fees were negotiated immediately after the Treasury negotiations and the Treasury fees were dependent on the increases recommended by the Review Body on Doctors' and Dentists' Remuneration.

After NHS reorganisation the work carried out for local authorities was divided into that for which they continued to be responsible and that for which health authorities undertook to pay. The latter are negotiated in the Joint Negotiating Body and are set out at the back of the "pink book." A new committee was set up to negotiate the remaining fees—the Joint Committee for the Fees of Doctors Assisting Local Authorities.

Both sets of fees were negotiated by the BMA in the brief pause between incomes policies that occurred after the 1975 Review Body report. If action had not been taken promptly the Association would have been overtaken by the next stage of incomes policy (August 1975).

Because both sets of fees are paid for services carried out for public authorities they were subject to the Pay Board and increases have been permitted since 1975 only in conformity with incomes policy. Other fees

(outside the public sector), such as life insurance fees, were subject to the policy on prices and were increased accordingly. So gross anomalies have occurred between public and private sector fees. A note on the BMA's claim to increase public sector fees was published on 6 May (p 1228).

In brief . . .

NHS electricians' strike postponed

The 5000 members of the Electrical, Electronic, Telecommunications, and Plumbing Union working in the NHS have postponed their threatened strike in support of a pay claim but decided to work to rule. A strike would have affected more than 100 hospitals. Last weekend several London hospitals cancelled admissions, including St Thomas's, the London, St Bartholomew's, King's College, the Royal Free, and Northwick Park.

Cameron Fund

The Cameron Fund was founded in 1971 to relieve "poverty, hardship, and distress" in general practitioners and their dependants. It was established with the residue of the Group Practice Loans Fund and named in honour of Dr J C Cameron, chairman of the GMSC at the time. The chairman's statement, produced for the AGM on 28 June, shows that in 1977, 74 families received financial help and the fund made grants amounting to £54 777. Most families became a continuing charge on the fund. There was a successful Christmas appeal, which raised £2700 and enabled gift cheques to be sent to the most needy beneficiaries.