GPs and IVB
A Qualitative Study of the Role of General Practitioners in the Award of Invalidity Benefit

Jane Ritchie

with

Kit Ward

Wendy Duldig

Social and Community Planning Research

London: HMSO
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Acknowledgements

This research was undertaken by Social and Community Planning Research on behalf of the Department of Social Security. We would like to thank Dr Mansel Aylward and colleagues in the Benefits Agency Medical Service, Mr Bob Layton and colleagues in the Policy Division, and Peter Craig and Carli Lessof of the Social Research Branch for their help and guidance throughout the study.

The evidence presented in this report is derived from interviews with 40 GPs. We are indebted to them for the time and thought they gave to the discussions and the openness with which they responded. This has been appreciated by all concerned with the study.
Summary of Main Findings

Aims and conduct of the study

1. This study among general practitioners (GPs) forms part of a programme of research to examine the factors that have caused the receipt of invalidity benefit (IVB) to grow. The central aims of the study were to explore the circumstances surrounding the issue or discontinuation of statements for IVB and to determine ways in which GPs might be assisted in their role in the award of the benefit. The study was qualitative in form involving in-depth interviews with 40 GPs. The sample was purposively selected to ensure maximum diversity in terms of practice size, catchment area and length of registration as a GP (Chapter 1).

Patients on IVB

2. It was not possible for GPs to give any precise figure for the number of patients on their lists who were receiving IVB. Such information was not available or easily extracted from medical records (Section 2.1).

3. The main conditions with which patients presented for long-term certification were musculo-skeletal conditions, cardio-vascular conditions, chronic obstructive airways disease and mental illness. Other conditions, like carcinomas, sensory impairments, neurological disease or severe injuries were also noted (Section 2.1).

4. The GPs were of the view that the majority of their patients who were now receiving IVB would continue to do so for the rest of their working lives. This low expectation of movement off IVB was based on a number of factors among which prospects of recovery and age were the most commonly cited. The patients' prospects of getting a job and their motivation to do so also distinguished those who might leave IVB from those who would not (Section 2.2).

Issuing statements for IVB

5. GPs were not usually aware of the point at which their patients changed from receiving sickness benefits (sickness benefit (SB) or statutory sick pay (SSP)) to receipt of IVB. There was therefore no immediate change in the basis on which judgements about capacity for work were made. GPs were not, generally, very conscious of the requirement to consider capacity for any type of work, rather than usual type of work, once IVB was in receipt (Section 3.1).

6. Statement lengths for IVB were commonly set at intervals of 13 or 26 weeks, occasionally shorter (i.e. four, six or eight weeks) and occasionally longer (i.e. a year). The factors that might influence the statement period were the patient's condition, the patient's age and their prospects of returning to work (Section 3.2).

7. GPs varied in the extent to which they recorded generic or specific diagnoses on statements. Specific diagnoses, as preferred by the DSS, may be avoided for reasons of confidentiality or fear of disclosure. General diagnoses are also more likely to be recorded when there is some uncertainty surrounding the condition (Section 3.3).
Discontinuation of IVB statements

8. The Reference Service was seen to play a vital role in the discontinuation of statements for IVB. This was either because GPs used the Service to get ‘back-up’ or second opinions for patients about whom they were uncertain, or because the Reference Service, through its own procedures, advised that ‘doubtful’ IVB patients were fit for work. In such cases, GPs were happy to agree (Section 3.4).

9. In other circumstances, GPs might suggest that the patient should consider returning to work and a timescale was mutually agreed. If the patient was not compliant with this suggestion then some negotiation needed to occur. Alternatively, patients themselves might initiate the ending of IVB. This most commonly occurred when patients had a high motivation to work or where the nature of the condition was such that recovery could clearly occur (Section 3.4).

Judging capacity or incapacity for employment

10. The factors that might influence a GP’s judgement about capacity for work are numerous and complex and have to be ‘weighed up’ in the case of each patient. Although the patient’s condition and its impact on employment potential are always high on the list, they are almost immediately interlinked with a whole range of other factors. These include the patient’s prospects of finding work, their age, their motivation to find work, the financial and psychological consequences of returning patients to unemployment or job search and their potential for rehabilitative training (Section 4.1).

11. The research suggests that the guidance given to GPs concerning capacity for employment is being extended such that:

(a) the judgement that the patient is ‘unable to work’ because of their disorder may be extended to include getting and retaining work

(b) the judgement that it would be ‘prejudicial to their health to undertake work’ may become broadened to encompass unemployment and job search.

Thus any patient, who, because of their condition, is unlikely to get a job, or keep a job, could be certificated on count (a). Similarly, any patient whose condition might deteriorate because of having to look for work or through the stresses of being unemployed might be issued a statement on count (b) (Section 4.1).

12. The GPs expressed varying levels of confidence in their judgements about capacity for work. Some said they felt fairly confident apart from the most difficult cases; some said it depended on the patient; while others said they were not very confident at all. The areas of judgement that GPs find most difficult concern the patient’s potential for alternative employment, retraining or occupational rehabilitation. Their main dilemmas arise from considerations of the patients’ psychological health, non-specific or difficult-to-diagnose conditions, the information on which a decision has to be reached, and the influence of local employment conditions (Sections 4.2, 4.3).

The role of the Reference Service

13. There was a widespread view among GPs that the Reference Service performs a crucial function in the assessment of patients for IVB, and that its very existence meant that there was a monitoring system in operation which offers review of, and support to, GPs’ decisions (Section 5.1).

14. There were differing views on the effectiveness and efficiency of the Service in performing its role. The main criticisms surrounded the remoteness of the Service, its speed of response for decisions, procedures for notifying patients of medical officers’ opinions, and the apparently ineffectual relationship that exists with the Employment Service (Sections 5.1, 5.2).
15. It was equally clear that GPs were not using the Reference Service to its full potential particularly when a second opinion was required. Part of the reason for this was a lack of knowledge and understanding of the way that the Service works and the facilities it offers (Section 5.3). A number of changes to the operation and procedures of the Reference Service are suggested (Section 5.4).

The GPs’ role in the award of IVB

16. GPs differed in their feelings about the role they play in the award of IVB. Some saw it as just part of their job or were simply resigned to the fact they had to do it; others saw it as rather more of a burden, at least part of which they would like lifted; yet others saw it as a major interference in their function as a doctor and would like the whole thing taken out of their hands (Section 6.1). Concerns about jeopardising the doctor-patient relationship are central to the difficulties GPs experience (Section 6.2).

17. The GPs identified a number of circumstances in which they felt their decisions about IVB were uncertain. The greatest uncertainty surrounds patients with conditions which are difficult to diagnose, those with associated stress-related problems, those who are unable to cope with their condition or with life’s demands more generally, inherited patients, and younger patients because of the dangers of becoming permanently incapacitated from work (Section 6.3).

Aiding GPs in their role

18. There was a widespread feeling that there needed to be some change in mechanisms for assessing capacity for employment. There were various solutions to this which ranged from having the function transferred to independent qualified assessors through to extensions of current Reference Service procedures. For similar reasons there were some GPs who wanted to disengage medical assessment from the consequences for receiving benefits (Section 6.4).

19. Other suggestions involving changes to the social security system, to the availability of employment programmes and services and to health services, were also made. GPs hold particularly strong views about referral of claimants by benefit offices to be on the sick: and about the apparent paucity of programmes and services for people requiring employment after a period of long-term sickness and disability (Section 6.4).

20. By their own admission, GPs need to extend their knowledge about the requirements and procedures for the award of IVB. The knowledge required includes information about local office procedures for review and control of IVB claims, the operation of the Reference Service and mechanisms for referral for employment or training assessment. Further guidance is needed on assessments of capacity for employment. The need for some feedback to GPs on the judgements they make was also identified (Chapter 7).
Chapter 1 Introduction

1.1 Background to the study

Invalidity benefit (IVB) is a national insurance benefit for people who are unable to work because of long-term illness or disability. It is payable after 28 weeks of incapacity, following a period of receipt of statutory sick pay (SSP) or sickness benefit (SB). In 1990/1991, there were 1.3 million people receiving IVB, of whom three-quarters were men and a quarter women.

Since IVB was introduced in 1971, there has been a continuing increase in the numbers receiving the benefit. In the last 10 years the number of people receiving IVB has more than doubled, amongst both men and women. For men, this growth is attributable to the lengthening periods of time that people stay on the benefit rather than to any increase in the numbers of new awards made. Among women, there has also been some increase in the numbers of new claims.

The Department of Social Security has undertaken a programme of research to examine the factors that have caused the receipt of IVB to grow. The research programme has a number of different components including a large scale cohort study of new claimants, a cross sectional study of IVB claimants of two or more years duration and an international comparative study of trends and solutions in other countries. The programme of work began in 1991 and is due to be completed later in 1993.

At an early stage of the research, an exploratory qualitative study was undertaken to help determine the influences affecting IVB claim durations. The study involved interviews with current claimants, former claimants and GPs. The preliminary evidence collected from GPs suggested that there were a number of concerns surrounding the issue of medical statements for IVB that required fuller investigation. A more extensive qualitative study among GPs was therefore commissioned, the results of which are documented in this report.

1.2 The aims of the GP study

The receipt of IVB is dependent on the issue of a doctor's statement certifying that the claimant should 'refrain from work' for medical reasons. Before issuing such a statement, the GP is asked to judge if the patient is unfit for all types of work, not just the person's normal occupation.

If a GP has any doubts about a patient's capacity or incapacity for work, they can refer the person to the Department's Reference Service for a second opinion. Similarly, claimants may be referred to the Service by local offices for an assessment of capacity to work. GPs may also be asked by the Reference Service to provide additional information about a patient's medical condition as part of the procedures for review and control of IVB claims.


2. The name of the service was changed in February 1993 from the Regional Medical Service to the Reference Service. The new title is used in the text of this report. However, the interviews were conducted at the end of 1992 and therefore the quotations from GPs refer to the Regional Medical Service.
The preliminary research amongst GPs identified a number of difficulties and dilemmas that doctors face when issuing statements to patients for the purpose of claiming IVB. It also raised some important questions about the GP's role in the award of IVB, the information and guidance available to them to fulfil it, and about contacts and communications with the Reference Service. In the light of such evidence, the extended study among GPs had three central aims:

- to explore the circumstances surrounding the issue or discontinuation of statements for IVB and the nature of any difficulties involved
- to identify the factors that are taken into account when judging capacity or incapacity for employment
- to determine ways in which GPs might be assisted in their role in the award of IVB.

It is planned that the evidence collected will be used by the Department, and by the Reference Service in particular, to develop further guidance, training and support for GPs.

1.3 The study design

Because of the nature of the information required, the study was undertaken using small-scale qualitative methods. The processes being discussed were complex and it was important that GPs had the opportunity to raise issues of relevance and concern to them. For this reason, the interviews held with GPs were flexible in their coverage and interactive in form.

The sample of GPs

The sample for the study was purposively selected to ensure maximum diversity of both practice types and GP characteristics. A selection of eight areas was made, covering inner city, urban and rural locations and different types of labour market. The areas were located in five regions of England (the North-East, West Midlands, East Anglia, London and the South-West) and in Wales.

The GPs were selected from Family Health Services Authority records in the areas concerned. The main criteria used for selection were practice size, length of registration as a GP, and gender. A total sample of 86 GPs was invited by the Department to take part, from which 40 were selected for interview. A profile of the GPs interviewed is given in Section 1.4.

Full details of the sample design and methods of selection are given in Appendix 1. It should be noted here, however, that the response from GPs to the invitation to take part in the research was excellent. This was partly a result of the method of approach used but, largely, we believe, reflects the importance that GPs attached to the study.

The interviews

It was felt that GPs could not be expected to give more than an hour to taking part in an interview. Because of this, the GPs received an advance letter from Social and Community Planning Research (SCPR) outlining the topics that would be covered in the discussion (see Appendix 2). They were also asked to prepare some collated information about their patients on IVB if this was possible.

The interviews were carried out using unstructured interviewing methods. They were based on a Topic Guide which outlined the key areas for discussion (see Appendix 2). All the interviews were taperecorded for subsequent verbatim transcription. The interviews ranged in length from three-quarters of an hour to two hours although most lasted just over an hour.

The interviews were conducted between September and December 1992.

3. Of the 86 GPs approached by the Department, five asked to be withdrawn from the sample. A further two were unwilling to take part when approached for an interview.
Analysis

The analysis was undertaken from verbatim transcriptions of the interviews. The method used involved the systematic indexing and charting of the verbatim text. This was carried out on a case-by-case basis using a common thematic framework for documentation.

1.4 The GPs and their practices

As previously noted, the GPs were selected to provide diversity both in terms of their length of experience in general practice and the type of practice in which they worked. A brief profile of those who took part is given below.

The practices

All of the GPs were from different practices, spread throughout the eight study locations. The catchment areas they served can be divided into three broad types:

<table>
<thead>
<tr>
<th>Practice catchment area</th>
<th>Number of GPs</th>
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</thead>
<tbody>
<tr>
<td>Inner city/large city</td>
<td>15</td>
</tr>
<tr>
<td>Urban/suburban</td>
<td>16</td>
</tr>
<tr>
<td>Rural</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
</tr>
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</table>

The areas varied considerably in the nature of local employment available. Two were largely dependent on agricultural work and tourism; two had a heavy industrial base, although in both cases declining; and the four urban and city areas offered a range of types of employment including services, light industry and, in two areas, heavy manufacturing work. Levels of unemployment ranged from 8% to 16%, relating to the practice areas of the GPs as follows:

<table>
<thead>
<tr>
<th>Levels of unemployment in the study areas</th>
<th>Number of GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 10%</td>
<td>8</td>
</tr>
<tr>
<td>10-12%</td>
<td>6</td>
</tr>
<tr>
<td>13-14%</td>
<td>10</td>
</tr>
<tr>
<td>15-16%</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
</tr>
</tbody>
</table>

Source: Employment Gazette, November 1992

An attempt was made to secure a range of sizes of practice, both in relation to the number of GPs in the practice and to list size. The distributions were as follows:

<table>
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<th>Number of partners in practice</th>
<th>Number of GPs</th>
</tr>
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<tr>
<td>Single-handed</td>
<td>10</td>
</tr>
<tr>
<td>2 or 3</td>
<td>10</td>
</tr>
<tr>
<td>4 or 5</td>
<td>14</td>
</tr>
<tr>
<td>6 or more</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
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</table>

<table>
<thead>
<tr>
<th>Total list size of practice</th>
<th>Number of GPs</th>
</tr>
</thead>
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<tr>
<td>Under 2500</td>
<td>9</td>
</tr>
<tr>
<td>2500 up to 5000</td>
<td>8</td>
</tr>
<tr>
<td>5000 up to 7500</td>
<td>9</td>
</tr>
<tr>
<td>7500 up to 10 000</td>
<td>5</td>
</tr>
<tr>
<td>10 000 up to 20 000</td>
<td>7</td>
</tr>
<tr>
<td>20 000+</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
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</table>

Practice list size, rather than the GP's personal list, is shown above because most of the group practices operated a reasonably flexible system for patients to choose the doctor they saw. Although most of the GPs saw a regular group of patients, there was the potential for any patient in the practice to consult them.
Ten of the 40 GPs who took part in the study were women and 30 were men. Among the women, two were part-time. The length of time the doctors had been in general practice ranged from two to over 30 years. The distribution of their experience was as follows:

<table>
<thead>
<tr>
<th>Number of years in general practice</th>
<th>Number of GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 years</td>
<td>8</td>
</tr>
<tr>
<td>5 up to 10 years</td>
<td>8</td>
</tr>
<tr>
<td>10 up to 20 years</td>
<td>11</td>
</tr>
<tr>
<td>20 up to 30 years</td>
<td>7</td>
</tr>
<tr>
<td>30 years or over</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
</tr>
</tbody>
</table>

Around three-quarters of the GPs had spent the majority of their time as family practitioners in their current practice. The remaining quarter had reasonably extensive experience in other practices.

1.5 The coverage of the report

The remaining chapters of the report detail GPs' experiences of, and views about, their role in the award of medical statements for IVB.

As will be evident, the research adopted a small-scale methodology in order to explore and understand the processes at work. Because of this, no statements of extent can be made. The purpose of this research was to extend understanding and to illuminate, not to quantify.

There are two observations about the evidence collected that should be made at the outset. First, each GP had a considerable amount to say and the data is rich in comment, illustration and suggestion. While this has been of considerable value to the analysis, it has also made it necessary to be selective in the amount of material presented in this report. Second, there was a high degree of consensus between the GPs in the experiences, views and judgements described. The issues raised were portrayed, explained and defended in very similar terms. Given the wide range of experience they had and the very different circumstances in which the GPs practised, such consensus should be noted.

Throughout the report use is made of quotation and case illustration from GPs. Where necessary, details have been changed in order to preserve the anonymity of the doctors and their patients.
Chapter 2  A Profile of Patients on IVB

It is an important context for the sections that follow to gain some understanding of the patient population that GPs were describing in their discussions about IVB. This chapter provides a brief profile of patients on IVB, as they were perceived by their doctors.

2.1 Patients currently receiving IVB

Numbers on IVB

It was not possible for GPs to give any precise figures for the number of patients on their lists who were receiving IVB. Such information was not available in their medical records. However, most of the doctors were able to give some rough estimate of how many of their patients needed statements for long-term sickness or disability. These estimates ranged from under 10 to 300 patients although the majority were describing a population somewhere under 100. Some of the GPs explicitly linked the number of IVB patients they had to characteristics of the practice catchment area and certainly most of the higher estimates came from areas with the highest unemployment rates. However, given the small size of the study and the very approximate nature of the estimates that GPs felt able to give, such associations can be viewed only with caution.

All the GPs said that the majority of their IVB patients were under retirement age although most GPs had a few who were receiving IVB beyond 60 or 65. Some of the GPs were aware of the current tax advantage of receiving IVB rather than the retirement pension: others were a little puzzled as to why their patients continued to claim IVB after the state retirement age.

The dominant conditions

Chart 2.1 lists the main conditions that GPs identified as being dominant amongst their patients on IVB. These categories - musculo-skeletal conditions, cardiovascular conditions, chronic obstructive airways disease and mental illness - were mentioned in some form by almost every GP. The following responses are illustrative.

"They may he cardiac, particularly in the older male. They may be musculo-skeletal, joint and physical back problems or I should think they may be psychiatric, psychological. I should think those are three main groups. Musculo-skeletal may have arthritis, osteo-arthritis, rheumatoid arthritis, back problems ... an injury at work. Cardiac are people who maybe have had a myocardial infarction, people with angina, unstable angina. Also people, whom I didn't mention before, people with severe asthma, severe chest problems .... '

[Female, 13 years as GP, group practice (3), inner city area]

'Lung conditions, chronic obstructive airways, these are patients who've got what used to be termed chronic bronchitis because of shortness of breath ... heart disease ... problems of joints ... osteo-arthritis of hips or knees. Then another large group, of course, are patients who are chronically anxious or depressed and feel that they cannot approach any work because of the stresses involved .... Well, of course, there are patients who have carcinomas, anaemia - I think those are fairly straightforward."

[Male, 21 years as GP, single-handed practice, large city]
Chart 2.1 Dominant conditions among patients on IVB

<table>
<thead>
<tr>
<th>Main conditions</th>
<th>Number</th>
<th>% (of total 1,305,000 all causes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the musculo-skeletal system</td>
<td>366,000</td>
<td>28</td>
</tr>
<tr>
<td>e.g.: arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disc lesion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>repetitive strain injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardio-vascular disease</td>
<td>291,000</td>
<td>22</td>
</tr>
<tr>
<td>e.g.: ischaemic heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive airways disease</td>
<td>104,000</td>
<td>8</td>
</tr>
<tr>
<td>e.g.: asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bronchitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>emphysema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental illness/mental disorders</td>
<td>207,000</td>
<td>16</td>
</tr>
<tr>
<td>e.g.: anxiety/depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>schizophrenia</td>
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chronic back pains, chronic sort of rheumatoid pains, by which I mean sort of muscular aches and pains or osteo-arthritis ... Then there are people with some inflammatory bowel disease that's poorly controlled ... people with some form of mental problem .... Musculo-skeletal problems I think forms the biggest group. Some with cardiac problems ... cardiac and respiratory problems - there's some in the older age group who have got chronic respiratory problems who are unable to work ... back pains who have genuine rheumatoid arthritis and osteo-arthritis and then you have something sort of somewhere in between that's very poorly defined, but I would have thought it's osteo-arthritis and mechanical pains that form the largest group ... stress-related problems - anxiety is the biggest one, that's a very difficult problem because obviously you've got the truly psychotic people that are schizophrenics but there is a large group with stress-related symptoms who are unfit for work for one reason or another ....

[Male, 3 years as GP, group practice (4), urban area]

Back pain is a quite common one, one or two people with osteo-arthritis of hips and knees which prevents them doing physical jobs ... one or two people who've had heart surgery and can't work again. One or two people after coronary thrombosis, or heart attacks ... people with neurological disease who've had strokes and no prospect of improvement ... people with malignant disease ....

[Male, 22 years as GP, group practice (5), rural area]

The four dominant categories are no surprise. DSS statistics show that these conditions are four of the main categories that lead to IVB amongst the recipient population as a whole. As Chart 2.1 shows, these conditions accounted for 74% of all causes for people claiming IVB in 1990/1991.

Other conditions like carcinomas, sensory impairments, neurological disease or severe injuries were also mentioned by a number of GPs but, as in the cases above, often in a residual way. This is not because the conditions are viewed as less serious by GPs - indeed, quite the opposite - but because decisions about issuing statements are in the main more clear cut. This appears as a central issue in later sections.
Over the last five years, the number of people receiving IVB nationally has increased by over a third. GPs were asked if they had been aware of any recent changes in numbers receiving IVB amongst their patients and, if so, the factors they thought had contributed to this.

Leaving aside the younger GPs who felt in no position to judge, responses were mainly divided between those who thought there had been an increase in the number of patients for whom they now issued statements, and those who felt that there had been no noticeable change over the last five or so years. In the latter cases, however, GPs stressed how difficult it was for them to identify such changes in any quantifiable way. As has been described, the GPs are not in a position to gauge numbers very precisely and attempting to assess increases holds the same problems. In addition, the numbers of patients on IVB are small relative to the practice list as a whole, so changes could well go unobserved.

The GPs who had noticed an increase in the number of patients on IVB felt it had been caused by one or more of the following factors:

- higher levels of unemployment/redundancy and subsequent difficulties in finding work
- a decline in the availability of light work, particularly noticeable amongst some employers
- an increase in the incidence of certain conditions, most notably psychological and psychiatric disorders, in some cases related to the 'recession' or 'economic climate'
- increased claiming amongst particular groups, for example men over 50/55 and women more generally, again related to labour market conditions
- a greater incidence of referral of 'sick' claimants by Employment Services and DSS local offices
- claimants' preference to be on the 'sick' rather than on unemployment benefit.

There were two study areas in which one or two GPs felt that, over the last three to five years, the numbers of patients on IVB might have decreased rather than increased. This was thought to be due to a 'clamp down on IVB by the DSS'.

With the exception of psychiatric disorders noted above, the GPs were commonly of the view that the conditions that led to IVB had not noticeably changed. However, as some of them pointed out, this was a little surprising given changes that had occurred in the management and treatment of certain conditions, like heart disease.

### 2.2 Patients likely to remain on IVB

Without exception the GPs were of the view that the majority of patients who were now receiving IVB would continue to do so for the rest of their working lives. Some placed this majority at 70%, some at 80% or 90% but rarely any lower.

'I can see that possibly there's two or three [out of 30] of them that might improve but the majority will continue almost indefinitely.'

[Male, 21 years as GP, single-handed practice, large city]

'I would anticipate that of those that I currently see who have been off work six months or more ... 90% of them will never work again. If you were to push me and say, well, take the younger age group who are under 50 and who have a potential working life of 10-15 years, I would even say that, amongst those, over three-quarters of them won't work again.'

[Male, 5 years as GP, group practice (5), urban area]
'It's difficult to give a proportion but I think it will probably be as high as 80% I think probably as high as that.'

[Female, 8 years as GP, single-handed practice, rural area]

This low expectation of movement off IVB was based on a number of factors of which the most commonly cited were age and prospects of recovery. These in turn, however, were affected by a whole range of other influences which inhibit patients leaving IVB. Most significant among them are the patients' prospects of getting a job and their motivation to do so. It was these factors that GPs saw as distinguishing those who might leave IVB from those who would not.

'Age basically. These are the younger age groups who have got conditions which ought to be cured if the appropriate treatment is given, whereas most of the other two-thirds of my list have got much more chronic long-term disease. The short-term patients ... the back syndromes who are waiting surgery .. I've got a patient waiting for a knee replacement -- he's been on the club for nine months. I've got a patient with possible asthma and pericarditis who ought to be back at work. These are things which I reckon we ought to be able to treat expectantly and say those patients are fit for work. The rest of them have got things like chronic bronchitis, emphysema, cardio-vascular disease - they're probably 60 plus, the chance of them getting back to work is remote in my opinion.'

[Male, 30 years as GP, group practice (4), urban area]

'Yes, the acute, that kind of thing, the post-ops, it depends on the personality of the person, the post-ops. Yes, they will get back if they go over their six months, you know, fractured femurs, whatever, acute stuff like that and the chaps who had a genuine sort of medical illness if you like, and they're keen to get back, but I think the vast majority, you know, are not interested in getting back ....

[Male, 5 years as GP, group practice (4), rural area]

'Factors like approaching retirement age, I don't think one would expect this person to go back to work, number one. Number two is the type of work they have, whatever background they've had, again that goes into motivation as well people who've worked all their lives perhaps, people who have been sufficiently trained and like their jobs will go back to work. The people who think their job is a real pain, I don't think so.'

[Male, 3 years as GP, group practice (3), inner city area]

'I can't think of very many patients who I've been signing off chronically who've ever come off long-term certification. It becomes a way of life, I'm afraid ... I think that's reflected in the kind of patients we have here because a lot of them, well, they don't give up but their horizons are fairly limited in terms of job prospects even when they're able bodied ... and they don't have any inclination to think about going back to work. I mean it is very difficult then to motivate them to want to work and if they don't want to, you can't necessarily sign them off as fit again.'

[Female, 12 years as GP, group practice (5), urban area]

The issues raised in the above passages, which are central to the difficulties of discontinuation of IVB, are considered fully in a later chapter. What is apparent, however, is that a very low movement off IVB is perceived by doctors. This is reflective of the situation nationally. The reasons for this are the focus of most of the remaining chapters of this report.
Chapter 3 Issuing Statements for IVB

This chapter considers some policies and practices surrounding the issue of statements for IVB. It begins by looking at the transition point from sickness benefit to invalidity benefit and concludes with the circumstances surrounding the discontinuation of IVB. GPs’ practices concerning statement length and recording of diagnoses are also considered. It leaves aside the central question of how decisions about capacity or incapacity for employment are made, which is described in detail in the next chapter.

3.1 Entry to IVB

The guidance given to GPs about the issue of statements after six months or more of incapacity is as follows:

> when your patient has already been incapable of work in their normal occupation for 6 months or more and is likely to receive similar advice to refrain from that work for a further period, an open' statement should not be issued unless you consider that the claimant is unfit for all types of work and not just the work that was previously undertaken.'

[A Guide for Registered Medical Practitioners, Section 2]

For entry to IVB, the transition point normally occurs at the end of 28 weeks of receipt of sickness benefit (SB or SSP). During this earlier period, GPs are advised that they `will usually need to have regard only to the patient's normal occupation’ before issuing a medical statement.

All the GPs knew that IVB followed sickness benefit after around six months’ incapacity. However, they were not generally aware of the point at which their own patients changed from receiving one benefit to the other. As many of them commented, they would have no way of knowing about this transition unless their patients told them which some of them did - or unless they checked the records to find out the aggregate period over which statements had been issued. The total length of incapacity was not likely to be something that GPs held in their head, particularly as it usually built up through a series of short period (i.e. four or eight weeks) statements.

The GPs were very open in acknowledging their lack of awareness of when patients move onto IVB. In the main, they did not see it as something that they needed to know.

‘No, no, I'm not actually [aware], I don't think about that ... some of them will talk to me about it, but it doesn't really actually come into my way of thinking ...’

[Female, 18 years as GP, group practice (5), city area]

1. An open statement is issued in cases where the doctor judges that the patient will be unable to resume work within a period of two weeks. A copy of the medical statement (Form Med3) is shown in Appendix 3.

2. There are circumstances in which a change in the base of certification will not be coterminous with the transfer from SB/SSP to IVB. This can happen when the incapacity is not continuous and where IVB is attained through a series of linked spells (i.e. the permitted period of interruption), IVB will then be in payment before there is a continuous six-month period of incapacity in the current spell.
Not in the slightest [aware] .... The patients sometimes say to me, "I've had this note from the DHSS which says I'm to be an invalid now. What does it mean?" or something like this ... I just say that it's a technicality that the DHSS applies to you after six months and as far as I'm concerned it makes no difference at all.

[Male, 22 years as GP, group practice (5), rural area]

'No, I mean, I think to most GPs, well to me anyway, the person's off sick, you know. I don't notice this landmark six months go past ... it just happens .... If I just scan the record in front of me ... we will see straightaway how long they've been off ... but nothing would actually alert me unless I decided to look at the record.'

[Male. 7 years as GP, group practice (3), large city]

The fact that GPs were not aware of the beginning of IVB should not suggest that they were unaware of the patient's actual or potential invalidity. For some patients, it was evident during the period of sickness benefit that they were unlikely to return to work within six months and probably not at all. This was either because of the nature or severity of their condition or more commonly because of associated factors that suggested low prospects of a return to work. Similarly, it was usually evident to GPs sometime between six and twelve months that long-term incapacity was involved, at which point it would be clear that IVB was now being received. Alternatively, notifications from the Reference Service will alert them to this fact.

Once a patient has been incapable of work for six months or more, the GP has to consider the person's capacity for all types of work and not just the work previously undertaken (see extract from Guide, page 12). Technically, this change from judging capacity for previous work to capacity for any type of work should occur as the award of IVB begins.

Since the GPs did not usually know when their patients transferred to IVB, it is clear that there could be no related change in the basis on which judgements about capacity for work were made. As a consequence, when patients receive their first statement of incapacity for IVB, there will not be any immediate switch from judging capacity for usual work to capacity for any work. But the situation is more complex than this as the following analysis shows.

When GPs were asked how conscious they were of the requirement to consider any type of work, a number said they were not conscious of it at all or did not know that this was something that they were meant to consider.

'No [I am not conscious of change]. This is most interesting - because of course, there is this big problem of the argument people have that 'I couldn't become a policeman again' ... they say they need a note to say they can't work and we do have these - well, not arguments, but discussions about. Well you are unable to become a policeman again, yes, but you might be able to do something else .......... - I suppose after about a year ... I would consider alternative employment.'

[Male, 19 years as GP, group practice (6), rural area]

'The change doesn't register, I have to be honest. I think you're still considering "Are they fit for the work they had?".'

[Male, 17 years as GP, group practice (4), suburban area]

Well if I get a request saying "Is this person fit to do another job?" and they mention a specific job, then I presume there's something to fill up saying yea or nay or what they can do and what they can't do, but that's usually done by either the DRO [Disablement Resettlement Officer] or the RIM [Regional Medical Officer] ... they call them in regularly ... that happens automatically. It's not for me to decide on that one, surely.

[Male, 30+ years as GP, group practice (3), rural area]
Whether they knew of this requirement or not, some GPs said that, in practice, they did consider other forms of employment, often before IVB began.

‘I think each time you sign the note, you’re thinking about their occupation; you’re thinking about whether or not you consider them to be fit for work. But with what you said about the difference between their normal occupation and any occupation, I didn’t realise it took six months for that to take force. I thought perhaps that’s the ease sort of nearly immediately when someone was off work that ‘there would be any occupation that they would be considered for...

[Female, 2 years as GP, group practice (2), urban area]

‘I think it’s an on-going thing. As soon as the patient is unfit for work, you think what they can do........ I wouldn’t say there was any particular cut-off .... One or two I can think of have been retrained but that appears to be difficult now, they seem to have to wait an awful long time to get retrained. And then, of course, with the present economic situation they can’t get a job then and I feel its unfair to put them ... say they’re fit for work, when they can’t get a job, so I do sometimes continue to sign a certificate if they’re not fit to do their original work.’

[Male, 30+ years as GP, group practice (4), urban area]

Yet others argued that it was a difficult requirement to operate at any stage because of the employment situation.

Not very conscious at all ... I mean 90% of cases, the patients, if they can’t carry on their usual employment ... are unlikely to find another type of employment ... because there aren’t any jobs and because training facilities are abysmal.’

[Male, 21 years as GP, single-handed practice, large city]

‘I think it’s very, difficult to be honest, from my point of view. I mean that is how ideally we want to do it and I do think that. But to be fair, in the current climate when they’re not going to be picked for any job it’s very difficult for them .... Some of them do try and say well perhaps they are fit for something but actually saying that to them, you physically make them ill. Depressed, anxious, to such an extent that they can’t cope, couldn’t cope, with the thought of it, of doing any job, so you’ve got to look at it that way.’

[Male, 4 years as GP, group practice (5), urban area]

It is evident from these responses that the guidance given to GPs is not being operated as planned. The GPs lack of awareness of the requirement partly explains this, but there are more fundamental problems at issue. These concern the difficulties that GPs have in first making, and then implementing, their judgement about capacity for employment. By comparison, the question of whether they are judging capacity for a usual kind of work or any work generally assumes lower significance.

The impact of being on IVB

A number of the doctors felt that moving onto, or being on, IVB had a significant impact on their patients. This was seen as detrimental for some, but advantageous for others, based on three lines of reasoning.

First, it was felt that being on IVB could represent confirmation of invalidity. For those with serious impairment or a terminal illness this was often distressing. Conversely, for those with less well defined conditions it could be reassuring. Either way, there were features of the benefit which confirmed permanence, the name itself being one.

Another line of argument was that, with very important exceptions (e.g. cancer, progressive diseases, severe injuries, etc.), there were now relatively few illnesses which in themselves required a period of longer than six months for recovery. Improvements in treatments for conditions like bronchitis, and changes in
rehabilitation programmes for people with heart conditions or in post-operative recovery, meant that people could, if they wanted to or had the opportunity to, be back at work within six months. If they were not, then other complicating factors were likely to be operating which in themselves may be indicators of future IVB certification.

Thirdly. some GPs were of the view that once people had been out of work through ill health for a significant period, their chances of returning to employment were low. Some GPs placed this period as within six months, others at 12 or occasionally 18 months, but never any longer.

In the light of these factors some GPs argued that by the time patients were on IVB, it was getting late for action. Any intervention had to occur at an earlier stage, during receipt of sickness benefit;

'It is within the six months invalidity benefit cut-off point, in my opinion anyone who's been off for more than three months, that's where I start to change ... I start to explore what the problem is, why they need to be off work for so long, from the sort of very purely medico point of view because usually most things get better after three months, four months at the most ... I feel that someone perhaps doesn't like his job and want to be on long-term sick ... then I usually refer them for a specialist opinion ... I don't use the six month cut off point because they're going on invalidity ...

[Female, 7 years as GP, group practice (6), inner city area]

'The problem is sometimes that you realise that they've been signed off for nine months and then you start, you try to - I mean I always do try at some point to talk about going back to work and I tend to do it earlier and earlier now, if I think there's any chance that this may go on ... I often try and do it before six months if I remember or they come to my attention. In practice I suspect that I sometimes do it before and sometimes do it after the six months, so it is variable.'

[Male, 3 years as GP, group practice (4), urban area]

'I'm not saying the patients are manipulating me or doing it deliberately but obviously they come to accept a condition once they're on invalidity benefit. They're coming to accept a stable condition with their own health and they're coming to terms with the fact that they're not going to be going back to work for a prolonged period ... I think [early intervention] is a possibility. I think it's a real need. There are some times when I feel its difficult to justifi this person being continually on sickness benefit ... and that's not fast the people who are sort of shown up through the Regional Medical Officer, but other people as well.'

[Male, 12 years as GP, single-handed practice. large city]

The final section of this chapter, which considers the discontinuation of B, returns to some of these issues.

3.2 Factors influencing the length of statement period

All the GPs described some 'rules of thumb' which they used to decide the period covered by statements. There were a number of factors that could affect the statement length which were weighed up in the case of each patient. Nevertheless, each doctor could identify the sort of circumstances in which statement lengths might vary, from which some common patterns emerge.

Length of statement periods

Statement lengths for IVB were commonly set at intervals of 13 or 26 weeks, occasionally shorter (i.e. four, six or eight weeks) and occasionally longer (i.e. a year). There were also some GPs who exceptionally issued statements for an indefinite period by recording 'until further notice'. On this latter point, practice varied. Some GPs did not, as a matter of policy, issues statements for longer than a year;
some said the rules did not allow them to do so; others said they would do so only in well defined circumstances.

**Factors influencing length of statements**

The factors that might influence the period for which a statement was issued were of three main kinds. These related to:

**The patient's condition.** If the patient had an illness from which they were recovering, or one which needed regular monitoring or treatment, then shorter statements tended to be issue. If the condition was chronic or deteriorating, or a permanent impairment or terminal illness, then statement lengths tended to be longer.

Age. Some GPs tended to issue longer statements to older patients, particularly those nearing retirement age. Similarly, some had a policy of giving shorter ones to younger people to avoid conveying a feeling of permanency to the patients about their medical circumstances.

**Prospects of returning to work.** Some GPs said that they issued longer statements when it was clear that the patient was unlikely to return to work. This was often related to both the patient’s age and condition as described above. Similarly, shorter statements were sometimes used to convey to patients that they should still be considering a return to work, particularly if the patient appeared to have given up.

The ways in which these factors interlink in practice are described by GPs below.

'I tend to prefer to keep specific times. Even some of the people who are very ill may be on annual certificates. There's not many I care to make indefinite .... It's the only way you're going to see them ... if they don't go to the doctor that terribly often .... You know you're going to see them when they come for certificates .... People on invalidity benefit have a longer period than people on short-term sickness, obviously .... I like to start with not more than four weeks but I think that once they've come to the stage when they're invalids, I tend to go to thirteen weeks, three monthly certificates and then, if it's a condition that's obviously not going to improve, then you put them onto six months and if there's no improvement after a couple of years you might put them onto twelve months.'

[Male, 30+ years as GP, group practice (2), city area]

'I would say six months, tend to make it recurrent six months ... occasionally I put "until further notice" ... when it's been very clear that this patient would not work .... I don't do "until further notice" certificates for any of the conditions we've said - chest, back, mental illness, because there may be developments that may well cure them of their problems, though unlikely .... Six months because the chronic conditions that they have are unlikely to make a dramatic recovery within the intervening period of time and after all we have to remember that most patients who have gone onto a cycle of chronic invalidity have probably for the first one, two or three years of that illness seen the doctor much more regularly.'

[Male, 5 years as GP, group practice (5), urban area]

'It depends on how much treatment I'm giving then for the complaint from which they're suffering. Some patients I'd sign for 26 weeks at a time, some 13. Twenty-six weeks - probably rheumatoid arthritis ... valve problems ... Parkinson's disease in a man of 55 who is really quite severely affected, I don't really want to bring him back every month to get his certificate .... Long-term is either 13 or 26 weeks. Others come in every four weeks because they are on active treatment; some come in every eight weeks for the same reason. [It's affected by] the pernicious of the complaint and whether or not I'm giving any active treatment and trying to follow up their response ....

[Male, 30+ years as GP, group practice (5), urban area]
Three months usually, sometimes six months, one or two patients are signed off for a year ... it depends on age. The younger patients I tend never to give longer than three months because there is a better chance of employment and recovery at that age....

[Male, 4 years as GP, single-handed practice, large city]

As can be seen from the illustrations above, some GPs made a clear connection between the statement length and the frequency with which they wanted to see the patient. Others saw statements as being for more administrative purposes which were not connected with their medical treatment and monitoring. But virtually all GPs identified some patients for whom the issuing of a new statement was the only means of ensuring that the patient came to see them so that their treatment or condition could be monitored. This may occur, for example, with conditions which have stabilised or are being treated by long-term medication (e.g. hypertension, asthma, angina, arthritis, recurring back pain, schizophrenia) where the patient may no longer require active involvement (other than repeat prescriptions) from their GP.

There was some confusion over what was permissible, or preferred, by the DSS in terms of statement lengths. As indicated above, some GPs believed that it was not now acceptable to the Department to issue indefinite statements, a requirement that they thought had recently been changed. There was also a view among a few GPs that the DSS preferred longer statements for administrative reasons. In one case, the GP said he had been told this by his patients.

Those that are better motivated, they often say to you for instance, "Oh, I don't want a longer certificate, Doc" ... if you give them a month or eight weeks sometimes. "I don't want it any more 'cos I'm hoping that I'll feel better"... Sometimes what happens is that, they say, "The clerks at the DSS or whatever are getting a bit tired of these shorter ones, can't you give longer ones." ... I give a longer one as a rule because then that lets me off the hook and lets them off the hook in a way because they can blame the clerk for the thing but it doesn't really affect their pride.

[Male, 30+ years as GP, group practice (5). inner city area]

Unlike the case above, most GPs thought that patients generally preferred longer statements. Indeed, a number commented that patients often reacted badly if statement periods were on the shorter side. This was particularly true if there had been some reduction in the period covered. In this context, inherited patients who had been issued long-term statements by another doctor were cited as a problem.

My general tendency is to sign people off for reasonably short periods of time when I have some doubt as to whether they ought to get back to work or whether I'm going to refer them to the RMO or whether I'm going to persuade them that they are not sick anymore .... In those circumstances, the patient might be after a very long sick note and I might only give them four weeks ... or a patient who's new to my list and says "My previous GP always used to give me a six months certificate." ... and I'll say, "Right, I don't know anything about you. Have one for a month. By the time you come back, I'll have your old notes."

[Male, 11 years as GP, single-handed practice, inner city area]

Some doctors also cited patients for whom they felt it could be psychologically harmful to have long-term statements. This was particularly so in the earlier stages of IVB when the realisation of long-term incapacity may be first occurring. Similarly, some GPs felt it was dangerous for patients who were more accepting of their 'invalidity' to issue long statements at the start of IVB.
3.3 Recording of diagnoses

The diagnosis recorded on the statement is used by the DSS for review and control of IVB claims. GPs are reminded of this in the Guide:

"The diagnosis on which your advice about refraining from work is based should be entered on the statement as fully and accurately as the evidence available allows (but see Section 10). The diagnosis on statements is used as the basis for some statistics about the incidence of disease. This entry is also used by the Department of Social Security in considering continued entitlement to incapacity benefits and may be similarly used by employers for Statutory Sick Pay."

[Guide for Registered Medical Practitioners, Section 1]

Later sections of the Guide give some more detail about what is required and the circumstances under which a vague diagnosis may be recorded.

The GPs varied in their orientation towards specific or generic recording when writing diagnoses on statements. Some said they always tried to be as specific as possible as they believed this was in the interests of everyone, including the patients. Some said they varied their practice depending on the circumstances while others more usually recorded general diagnoses.

'I tend to try and be specific because I think it's important and most of the patients understand ... [specific] for audit purposes. I don't think it makes any difference to the patient being off. I just think it helps to keep records better .... I'm a very clear cut, specific sort of person -- I think you've got to be to a certain extent in medicine .... If you use vague terms to another colleague, he's going to look at you in rather a funny manner .... You've got to be professional about it and give a fairly clear cut diagnosis if you can.'

[Male, 4 years as GP, group practice (6), large city]

'It depends on whether there's a specific diagnosis or not. I think if someone has an identifiable problem then on the whole one will try to be specific but there is a problem with certificates in that sometimes the reasons are more complex. I mean they may have osteo-arthritis in the knee but they may have other problems as well. But I think one on the whole tends to wait to give a specific diagnosis or specific reasons for them not being at work. I must admit I do, with a large number, with a group of people, put a non-specific diagnosis if I don't know what it is ... certainly with stress-related illnesses and with back pain -- I mean if you've got back pain, that's not really a terribly specific diagnosis .... If I knew [the cause] I would put it down, but I mean back pain's not a very good choice because doctors on the whole are lousy at making a diagnosis of the cause of back pain. It's also very difficult to quantify someone's disability from it as well. It's a very non-specific diagnosis.

[Female, 12 years as GP, group practice (4), urban area]

'I leave it vague ... basic confidentiality .... If you've got somebody like this chap ... we were querying a possible DS [disseminated sclerosis] case. Nov, we weren't sure of the diagnosis; we just put down a vague symptomatology ... low back pain or poor co-ordination ... and once the diagnosis was clinched ... I mean. I wasn't going to write down "multiple sclerosis" every time the chap came in for a certificate, no way ... [in other cases] more likely to be vague than specific, just the confidentiality part of it ... it's legally important. I mean if you disclose something which you shouldn't ... they go to companies ... Anyone else can look at them as they come through ... there's no confidentiality at all.'

[Male, 30+ years as GP, group practice (3), rural area]

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3. Vague diagnoses are permitted if the GP feels it would be harmful for the patient to know the true diagnosis or if it is undesirable for the patient's employers to become aware of it.
Whatever their usual policy, all the GPs identified circumstances in which they either could not -- or preferred not to -- write a specific diagnosis. The main reasons for this were as follows.

- **A specific diagnosis is not possible or not known.** Commonly mentioned in this context were musculo-skeletal conditions, particularly bad backs and nervous or psychiatric disorders. It may also happen in the case of other disorders where medical investigations are still ongoing.

- **Multiple conditions.** In cases where there is more than one condition affecting capacity to work, it can be difficult to specify the diagnosis causing the absence from work.

- **It allows for a margin of error in uncertain cases,** particularly if the cause of a condition cannot be determined.

- **It avoids disclosure to the patient,** where the full diagnosis may not have been declared or where written evidence of the diagnosis could be distressing.

- **It preserves patient confidentiality,** primarily in relation to employers. This appears to be a carry over from issuing statements for sickness benefit since relatively few IVB patients would be sending certificates to employers.

- **It is easier for patients to understand.**

- **Implications for industrial injury claims,** particularly if the condition is one that is not yet fully diagnosed.

A general conclusion from these comments is that, with the exception of cases where GPs do not want their patients to see the diagnosis, general diagnoses are more likely to be written for conditions where there is some uncertainty about their cause.

Some GPs were very clear that the diagnoses they recorded were used for monitoring and control of IVB. Indeed, some of them gave this as one of the main reasons for trying to be as specific as possible. But some who were clear about this felt it more appropriate to write reasonably simple diagnoses since the people who would be looking at the certificates would not ‘know medical terms’.

‘I don’t feel that being too specific about the long-term diagnosis is that helpful .... The people dealing with the fauns are clerical so putting complicated diagnoses down won’t necessarily help the patient, it might confuse the clerk ... it might result in them having, you know, a transcription error .... If somebody wants something more specific they’ll often get a more specific diagnosis and examination.’

[Male, 12 years as GP, single-handed practice, large city]

It was evident in other cases that the use of diagnoses by the DSS was not considered at all, or perhaps not known about, by GPs. A few of the doctors commented that if the Department had particular requirements concerning the recording of diagnoses then they needed to instruct GPs more clearly.

*If the DSS wants to particularise these conditions better, they’d have to put it down .... We have some sort of loose directions now - they say try and be as specific as possible ... but there’s no bite in those directions and after all it doesn’t matter what you put down really, does it, because the thing is accepted .... If there was like, for instance, they have on death certificates ... they lay them down very clearly.*

[Male, 30+ years as GP, group practice (3), inner city area]
3.4 Discontinuation of IVB statements

The award of IVB can come to an end in one of three ways: the claimant, having recovered from or stabilised or adapted to their condition, may initiate movement off IVB through job search or re-entry to employment; the GP may initiate the end of IVB by no longer signing statements of incapacity; or the GP may be advised by the Reference Service that the claimant has been judged fit for work, at which point the GP will usually discontinue signing statements.

The GPs were asked about these different circumstances in which IVB can end, and which, in their experience, was the most common. Some GPs were of the view that initiation by the patient was extremely rare; others could think of several cases where this had happened. The circumstances in which it occurred, however, seemed to be well defined. Essentially, they revolved around patients who had a high motivation to work, or where the nature of the condition was such that recovery could clearly occur.

'I think it very much depends on the individual. I think someone who's had a by-pass graft and is determined to get back to work - I have one chap who is a roofer and really we're a bit worried about him climbing up his ladders, but he's determined to work and he's signed off as appropriate to work both by the hospital and myself. Whereas others who are more reluctant to return to work, (I think we are more lenient with them quite honestly. I think it very much depends on the motivation of the individual who has a particular illness.)'

[Female, 13 years as GP, group practice (3), inner city area]

'Their condition has either been treated or has got better and a job opportunity has come along or their circumstances have changed. And patients that have got really quite serious disabilities, it's amazing how much work they can do if they are motivated. So yes, the patient's attitude is very important.'

[Male, 21 years as GP, single-handed practice, large city]

Some of the doctors said that it was often a mutually agreed decision between the patient and the GP. Others said that they might raise the issue with the patient when they thought that their condition now permitted a return to work. Some patients responded to this very positively and there was, again, a jointly agreed plan for IVB statements to end.

'I think it's about fifty-fifty. A specific condition where somebody's had a rather traumatic time getting over surgery, for example, and you're obviously working towards a time when they are going to get back because they're going to get almost, well 80% - 90%, better, almost to where they were before, then that's obviously a joint thing but mainly, I would push the patient to sort of say, 'Well that's the sort of date that we are looking at for you to go back to work I think it tends to be more possibly on my side than on the patient actually finding something and wanting to be signed off.'

[Male, 23 years as GP, single-handed practice, rural area]

A GP's suggestion that the patient should consider returning to work is not always positively received. Indeed, one of the major difficulties confronting GPs occurs precisely in this circumstance. They, as doctors, might feel that the patient is capable of returning to work but the patient might not be receptive to this advice. One of two things may then happen. The GP may warn the patient that they will not continue to sign statements indefinitely and at some point the statements will end. Alternatively, the GP may attempt such action, but in the end continue to sign. According to GPs, this is the more usual circumstance.

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4. Discussion of what GPs do when they disagree with the examining officers' opinions appears in Chapter 5.
The role of the Reference Service in bringing IVB to an end is considered in detail in Chapter 5. It is important to note here, however, that many of the GPs saw the Service as playing a vital role in the discontinuation of statements. This was either because the GP used the Reference Service to get 'back-up' or second opinions for patients about whom they were uncertain; or because the Service, through its own procedures, gave advice about the most doubtful cases with which the GP was happy to agree.

There are three general points that emerge from the GPs’ descriptions of the discontinuation of statements. First, almost every GP described a gradual ending to IVB, even in cases where the patient was quite compliant with the decision. The patients therefore had warning that it was going to happen and could prepare themselves -- psychologically and practically -- for re-entry to employment. Second, the timing of any intervention for consideration of a return to work was important. It had to happen relatively early in the history of IVB. Once the patient was beyond a certain point in time and in acceptance of their ‘invalidity’, the prospects of a return to work became remote. Once this point was reached, GPs could easily become immobilised by all the dilemmas involved (described later in the report) about returning their patients to unemployment. Finally, there is an issue concerning the conditions from which many IVB patients suffer. As was described in the previous chapter, in many cases they are chronic conditions from which the patients will not recover. They may not, in themselves, prevent the patient undertaking some work but they are sufficiently serious to limit capabilities. The question for a GP is whether they warrant a long-term incapacity benefit, particularly at a time when jobs and opportunities for employment training are limited.’ In the main, GPs conclude that they do.

This latter point raises more general questions about why movement off IVB is limited. As was described in the previous chapter, the GPs expected the majority of their patients on IVB to continue receiving the benefit. Although there were clearly cases where either patients or GPs initiated the end of receiving statements, relatively few instances could be cited. This should not suggest that GPs do not attempt to help patients return to work – some very clearly do. However, it seems that, in many cases, these attempts fail unless there is some intervention or back up from the Reference Service. The reasons for this are all connected with the difficulties or conflicts of interest that GPs have in performing their ‘benefit awarding’ role. These are explained more fully in later chapters, particularly Chapter 6.

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*a* in theory, GPs should not be influenced by local labour market conditions or unemployment rates when deciding on the issue of statements for IVB. This point is further discussed in Chapter 4.
When GPs issue a statement for IVB, they have to form a judgement about whether or not the patient is capable of work. It is this judgement that lies at the heart of their decision to advise that the patient should refrain from work. This chapter is devoted to the question of how, in practice, GPs judge capacity or incapacity for work.

The guidance given to GPs on the issue of statements for state incapacity benefits is as follows:

> It is important that statements advising patients to refrain from work should be given only when in your opinion,

- the patient is definitely unable to work because of their physical or mental disorder;

or

- although physically and mentally capable for work it would be prejudicial to their health to undertake it.

[Guide for Registered Medical Practitioners, Section 2]

As already described, in forming these opinions, doctors are asked to consider whether the patients may be capable of alternative work even if they are not able to return to their normal jobs.

4.1 The influential factors

Before attempting to identity the various factors that GPs take into account in judging incapacity for employment, it will be useful first to hear some accounts from GPs themselves.

The first thing, I suppose, is if their medical condition will get worse if they work, so you'll look at their medical condition and say if you carry on doing that particular job you're going to get worse so you must stop work.” Secondly, that they're waiting for treatment, and some things you have to wait for, like hip replacements and knee replacements, so that you know that they are going to have to be off work, so that's cut and dried. What other decisions? Well, I suppose it's really their medical condition that's the thing you look at first. I mean there are some people you look at, particularly nervous debility type ladies and I think, “Well, nobody is actually going to employ you anyway so because you are unemployed, will I therefore define you as sick?” Perhaps it's wrong but I think that's what I do think, ”Yes, you have got a condition that makes you unemployable therefore you must be sick .... ” Well, I try not to [take age into account] - I don't think so “ because I like to think that patients want to go on working to retirement .... I try not to bring age into it all.... I do think in terms of their usual employment, yes. Sometimes we'll sit and discuss what you could do instead, because a lot of them aren't very well trained and ... they are going to have to be motivated to go on to further training, which I know they've got to do, a certain amount of them ....

[Female. 18 years as GP. group practice (5), large city]
I suppose the factors are the nature of the condition itself certainly, yes and the person's constitution as to whether or not he is capable of overcoming what he has got sufficiently. I suppose the patients own wishes themselves must be taken into account. I think doctors, really - I don't think anybody would say i/c couldn't take, don't take, that into account; they must do .... I think the change in the way the social net has been cast in recent years ... must make some people think, "Well, it doesn't really matter if I'm on one benefit or another," because you know these people are just getting put into a slot. I think /age/ must come into it really. If you get a bloke who's 63, he's coming towards the end of his thing and he's obviously just hanging on, you know, before he finally gives up and comes to me. and he says, "Zook, I can't do it any more and they don't think I can do it any more either." I certainly do take that into consideration and if there's two years to go or something, there's no point to keep sending him back .... I often ask patients why can't they go and seek some training to do something else. Unfortunately there doesn't seem much facility for doing that --- even the ones that have been retrained, I don't think they find much cork at the end of it. I mean the whole exercise seems to have minimal results ....

[Male, 32 years as GP, group practice (4), urban area]

'What they are able to do and what their incapacity prevents them from doing ... what they were previously doing or what is a reasonably, likely thing for them being able to do. The majority of these ones that are coming in now have worked in reasonably heavy industry, and that has now been squashed and destroyed so we haven't any heavy industry any more. They're people who are used to lagging things around as fitters or dockers or something like that. and that is all they have ever done in their lives. I don't somehow think that they are going to make good computer operators. I wouldn't think that there's much point in trying to push them that way and certainly not when they are 55 or so because it's been going on for six months, and if somebody's been unfit for six months and they're 55 and they're unable to do the job that they are trained for, are we going to say, "Yes, that person must be trained to do something totally different, totally alien to anything they've experienced at all, is that a realistic option?"

[Male, 27 years as GP, group practice (2), urban area]

'It's not simply the medical condition --- part of it is social as well, I mean take the medical side of things, you have to determine whether physically he's capable of doing the job or any sort of job and then you've got to consider what effect returning to employment will have on his physical condition or his medical condition, plus the fact, you've got to look at the social aspect of his ability to return to work and still, you know, be financially viable .... You've got to weigh these things up ... age, yes I mean somebody who is 50 plus, if they have been on invalidity benefit and you say right, that seems to be a bit better now, you know, we'll sign you off and he'll say, "What can I going to do, Doctor?" you know. The chances of somebody over 60 getting any sort of employment round here is very slim indeed.'

[Male, 23 years as GP, group practice (4), rural area]

In feature if not in detail, responses of this kind came from virtually every GP interviewed. The patient's condition and its impact on employment potential are always first on the list. But these are almost immediately interlinked with a whole range of other factors among which the patient's prospects of finding work, their age, and their motivation to find work commonly occur. Interwoven with these are other influences, like the psychological or financial consequences of returning patients to unemployment or a search for jobs, or the limited availability or potential of rehabilitative training. Thus the factors influencing GPs' are numerous and complex and they have to be 'weighed up' in the case of each patient.

The full range of factors that might influence a GPs' judgement about capacity for work is listed in Chart 4.1. As can be seen, the full list is extensive. Although it is possible to describe and illustrate each of these in detail it is more useful to consider how the different factors may come into play.
### Chart 4.1 Factors taken into account in judging capacity/incapacity for employment

<table>
<thead>
<tr>
<th>MAIN FACTORS</th>
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<tbody>
<tr>
<td><strong>CONDITIONS OF INCAPACITY:</strong></td>
</tr>
<tr>
<td>- nature</td>
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<tr>
<td>- severity</td>
</tr>
<tr>
<td>- prognosis</td>
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<tr>
<td>- treatment (receiving or planned)</td>
</tr>
<tr>
<td>- effects of medication</td>
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<tr>
<td>- advice of specialist</td>
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<tr>
<td>- patient's response to the condition</td>
</tr>
<tr>
<td>- length of time the condition existed</td>
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<tr>
<td><strong>EMPLOYMENT POTENTIAL:</strong></td>
</tr>
<tr>
<td>- to undertake usual/normal occupation</td>
</tr>
<tr>
<td>- to undertake other types of employment</td>
</tr>
<tr>
<td>- to be in employment at all</td>
</tr>
<tr>
<td><strong>JOB PROSPECTS:</strong></td>
</tr>
<tr>
<td>- nature of usual occupation</td>
</tr>
<tr>
<td>- nature of local labour market and level of unemployment</td>
</tr>
<tr>
<td>- ability to retain employment</td>
</tr>
<tr>
<td>- length of time out of work/on IVB</td>
</tr>
<tr>
<td><strong>EMPLOYMENT REHABILITATION/RETRAINING:</strong></td>
</tr>
<tr>
<td>- patients' potential for retraining</td>
</tr>
<tr>
<td>- availability in local area</td>
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<tr>
<td><strong>MOTIVATION:</strong></td>
</tr>
<tr>
<td>- to attempt alternative work</td>
</tr>
<tr>
<td>- to be in work at all</td>
</tr>
<tr>
<td><strong>AGE:</strong></td>
</tr>
<tr>
<td>- proximity to retirement age</td>
</tr>
<tr>
<td>- effects on job opportunities</td>
</tr>
<tr>
<td>- importance of younger patients returning to work</td>
</tr>
<tr>
<td>- limitations arising from natural ageing process</td>
</tr>
<tr>
<td><strong>PSYCHOLOGICAL STATE:</strong></td>
</tr>
<tr>
<td>- levels of stress/anxiety/depression (associated with, or in addition to, main condition)</td>
</tr>
<tr>
<td>- potential stress/anxiety resulting from a return to employment</td>
</tr>
<tr>
<td>- potential stress; anxiety resulting from a return to unemployment</td>
</tr>
<tr>
<td>- motivation to work/attitudes towards work</td>
</tr>
<tr>
<td><strong>OTHER FACTORS:</strong></td>
</tr>
<tr>
<td>- financial circumstances</td>
</tr>
<tr>
<td>- family responsibilities</td>
</tr>
<tr>
<td>- family stresses/marital relationships</td>
</tr>
<tr>
<td>- housing circumstances</td>
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<tr>
<td>- need for travel to work</td>
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</tbody>
</table>
First it would seem from the accounts above that decisions concerning ‘capacity’ for employment are being relatively broadly viewed. This is resulting in an extended interpretation of the guidance given which appears to happen as follows:

1. the judgement that the patient is ‘unable to work’ because of their disorder may be extended to include getting and retaining work
2. the judgement that it would be ‘prejudicial to their health to undertake work’ may get broadened to encompass unemployment and job search.

Thus, any patient who, because of their condition, is unlikely either to get a job or keep a job could be certificated on count 1. Similarly, any patient whose condition might deteriorate because of having to look for work, or through the stresses of being unemployed, might be issued a statement on count 2.

Two specific case illustrations help to show how these judgements operate in practice.

‘I can think of a particular chap. He’s a 55-year-old. A very competent, sensible chap who’s got a chronically painful and difficult shoulder, who worked as a representative for a company. I mean he’s been looking very hard for alternative employment which is lighter, but he’s not found any. And he says his chances are not very good of ever finding anything. I mean, on the whole I think doctors are receptive to this. They’re [patients] not trying to sneak out - they’re not trying to avoid work.’

[Male, 20 years as GP, group practice (5), urban area]

‘One I can immediately think of is a young lady in her early 30s, who has a chronic anxiety state. I would say that she has an inadequate personality, and she tends to move in circles in which she feels completely comfortable. If you put her outside that, her anxiety level rises and she doesn’t cope .... She used to be a secretary; she’s trained as secretary. From what I can gather, she was good at her job, but as soon as you suggest that maybe by going back to work, not only would it be the fact that she’d earn some money, but she’d increase her self-esteem ... I hit this wall. “I couldn’t cope, Doctor. ” She physically cracks up in front of me. It’s very difficult .... If you can get over that initial barrier that she will be better in work, in employment, for her long-term happiness and quality of life ... but I just cannot get her over that first hurdle, I cannot.’

[Male, 4 years as GP, group practice (5), urban area]

A second feature that is evident from the decisions GPs described is that the judgement about capacity for work may be overridden by some other influences. In other words, the issue of a statement for IVB may take factors other than capacity for employment into account. All of these factors are in some way embedded in the dimensions listed in Chart 4.1 but they are, by the doctors’ admission, moving them into ‘grey’ areas. Again, two specific cases will serve to illustrate.

‘I have, for example, a gentleman who is youngish - he’s in his mid-40s. He’s a heavy goods vehicle driver. That’s all he’s ever done and that’s all he himself thinks he would like to do. He developed very sudden severe chest pain .... His chest pain on exertion continued so we sent him to have angiograms done and he’d got problems with major vessels in his heart. He Is since had a by-pass operation ... he hasn’t worked for 18 months ... he’s now on invalidity, meaning that he’s not fit for any kind of work. Well, I don’t believe so, because he can drive his car, so really he can drive a taxi .... He should be able to do other things. So really, I suppose, he’s a kind of one who we should say “fit within limits”. But you say that and he would lose a lot of money from it because ‘fit within limits” means that he can’t continue to get his sick benefit, he can’t continue to get his insurance that he’d paid into for years and years, for if he is ill ... [description of further tests] he comes hack and says, “I’ve got chest pains. ” I’ve got to believe it .... I’ll give him a certificate because I can’t risk saying, “You’re fit. Go out and work and look for a job.” If he goes out and collapses in the car park, I’m in the soup.’

[Male, 23 years as GP, single-handed practice, urban area]
... she runs a house, got children, looks after her husband, does the housework and things, drives the car around, does the shopping .... She [has ME] and can't work as her previous job was teaching .... She can't go back to fill-time teaching but ... she could have a little part-time job ... so I would say she is fit for some work .... I've said to her that she's going to get fit, perhaps won't go back to teaching but to look for other work, but while she's getting invalidity benefit there's no incentive for her to look for other work .... I've known her for many }rears. I don't want to fall out with her, which is the problem of a little country practice, I know them all by Christian names ... and this is the difficult situation where I would rather not decide.'
[Male, 17 years as GP, single-handed practice, rural area]

The other influences raised in these illustrations are examined more fully in Chapter 6 where the broader questions involved in the issue of statements for IVB are considered.

It must be stressed that GPs are not making judgements about 'capacity' in a vacuum, but always in the context of a long-standing illness, impairment or health problem. Although these conditions may be affected by, or even prolonged by, other psychological, social or emotional factors, they are nevertheless evident in some form. This is a point that was constantly emphasised by GPs and needs to be continually recalled.

'One has got to look at the options they've got available, and if you're saying they're not fit for the certain type of work, but for another sort of work, that's fair enough except if that other sort of work is not there and they've got a genuine medical problem which is keeping them from doing the sort of work they are used to. Those are the issues that need looking at .... We're not talking about someone with a sprained ankle; we are talking about people with very serious disabilities too -- severe osteo-arthritis, multiple sclerosis, alcoholism ... we're not talking about people who just want to skive off work. People who want to skive off work, I don't give certificates to.'
[Female, 7 years as GP, group practice (6), inner city area]

4.2 The major dilemmas

Throughout the interviews, there was constant reference to the difficulties and dilemmas that GPs face in the issue of statements for IVB. Some of these relate to the broader question of the GPs' role in the award of IVB as described above. Many of them, however, concern the central question of how capacity for employment is judged.

The dilemmas appear to revolve around four main issues:

- **Considerations of the patients' psychological health**

  In general, the GPs did not have any uncertainty at all about trying to maintain sound psychological as well as physical health for their patients. This is not at issue. But, in relation to IVB, dilemmas begin to arise if a GP believes that the presenting stress, anxiety or depression are occurring because of the patients' employment situation rather than their medical circumstances. This is a fine line around which to make judgements. In this context also, GPs often spoke about the patients' own handling of, or response to, their condition and the difficulties surrounding those who 'don't seem to want to get better'. For some GPs, this in itself is a sign of psychological malaise and therefore enters the arena for consideration.

- **Non-specific/difficult-to-diagnose conditions**

  Difficult-to-diagnose conditions present dilemmas on two counts. First, there is a real problem with 'measurement' and this is particularly so for many back complaints - also for some forms of mental disorders and other conditions like ME. Second, the doctor is reliant on what a patient tells them.
In cases where there are any uncertainties about the validity of this, GPs usually give the patients 'the benefit of no doubt'.

The knowledge/information on which a decision has to be reached

A related point concerns the evidence on which a GP has to make a decision about employment capacity. As has been shown, there are numerous factors to be taken into account in which the GPs are heavily reliant on what the patients tell them about their employment capabilities. This is accompanied by what, on their own admission, GPs feel is a rather flimsy knowledge of what different types of employment might require. As a result, the doctors see themselves as having little alternative other than to accept the patient's evidence.

The influence of employment conditions

The previous section showed that, contrary to guidance, GPs take into account the patients' prospects of getting work within the local labour market when making decisions about employment capacity. Some GPs are quite defiant about this, and feel wholly justified in their actions in the interest of their patients' general welfare. Others are more uncertain about the legitimacy of this influence, but nevertheless feel it cannot be ignored.

In the light of these issues, it is easy to see why some patients are described as 'straightforward', 'clear cut' or even 'genuine'. Because of a clearly diagnosed condition, with evident limitations to employment capacity, none of the above concerns need to be taken into account. It is only when one or more of the elements discussed above arise that doctors' dilemmas begin.

GPs' confidence in their judgements

The GPs expressed various levels of confidence in their judgements about capacity for work. Some said that, with the exception of the most difficult cases, they felt fairly confident; some said it depended on the patient; while others said they were not very confident at all.

Although some of the GPs commented that their confidence had grown with experience, there were others who felt this was not so. Indeed, they argued that because of the 'economic climate' judgements about capacity were now more difficult to make, which left them feeling less, rather than more, confident.

As the previous section showed, GPs face a number of difficulties in judging capacity, and these were experienced by every GP, however confident they felt. But there were other anxieties about whether GPs were really equipped to make the necessary judgements.

'I think probably that one doesn't perhaps know enough about this field well one knows less about this field than other people .... They maaa know more about the likely sort of occupations that the person could be fitted into, what a person's chances at a particular age group are of getting a job, how much the person's existing levels of skills can be brought into play in teaching him something new. I mean I can think of lots of areas'
[Male_ 20 years as GP, group practice {5}_ urban area]

This GP had many years of experience and said he felt reasonably confident in most of his judgements. But, as is evident, there are areas where he felt that he did not have sufficient knowledge or that someone else could do it better.

There are three areas of judgement that GPs find particularly difficult:

Potential for alternative occupation. It has already been shown that GPs vary in the extent to which they take alternative work into account when issuing statements for IVB. In discussions about judging capacity for work, it becomes much more
evident that many GPs do not - or feel they cannot - judge a person's potential for other work. As a result some GPs say explicitly that they leave such assessments to the Reference Service. Others feel they are making such assessments from a very poor knowledge base. It was also felt by some to be quite outside the GP’s jurisdiction.

‘... I’ve got a patient who has osteo-arthritis in his knees and he works as a carpenter. Well, most joinery jobs ... are actually spent on your knees, and so the pain is made worse, and he has difficulty getting up and walking around, so obviously osteo-arthritis affects his ability to work in a much greater way than if you’re actually sitting behind a desk .... I don’t feel that it’s my job to actually tell him or make enquiries as to what other work to get ... I have other things that are more important for me to be doing with my time than being a careers advisor.’

[Female, 8 years as GP. single-handed practice, rural area]

**Potential for retraining/occupational rehabilitation.** In a similar vein, GPs feel very unsure about how successful it would be for patients to be retrained or go through some form of occupational rehabilitation programme. On this issue they feel quite clear that they have not got the skills or expertise needed to make an assessment. As a consequence they either rely entirely on the patient’s judgement or might seek the advice of the Reference Service. They might also refer the patient to the Disablement Resettlement Service (DRS) although, for reasons discussed below, this was rare.

**Opportunities for retraining/occupational rehabilitation/assessment.** GPs were of the view that there were some patients for whom they were signing incapacity statements who could work if they received appropriate training or rehabilitation. As discussed above, the GPs do not feel capable of judging what the patient could do, but on the basis of their assessment of the patient, they feel something might be possible. With some notable exceptions, they did not refer such patients to the DRS - as they are advised to in the guidance - for three reasons:

- they are not sufficiently aware of the services that are available
- they believe that the services available are inadequate
- their patients -- and they themselves - have had unsatisfactory experiences when they have made referrals in the past.

The three areas in which GPs feel ill-equipped to make judgements about capacity for work lead to a persistent call for a stronger referral and assessment system. For some patients, further training or advice for GPs might help to solve difficulties concerning the person’s occupational potential. For others, however, a deeper knowledge of occupational or skill requirements was needed - an expertise which is seen as beyond a GP’s field. It was these latter cases, particularly those requiring occupational rehabilitation or assessment, for which GPs called for external referral. This is discussed in detail in the next chapter.
Chapter 5  The Role of the Reference Service

The Reference Service provides a referral system for local offices for cases where opinions on capacity for work are needed. The Service plays a key role in the review and control of claims for IVB. This chapter describes how GPs view the role of the Reference Service, the use they make of it for referral and the suggestions they have for ways in which it might be changed or improved.

5.1 Views and experience of the Reference Service

There was a wide spread view among GPs that the Reference Service performs a crucial function in the assessment of patients for IVB. Its very existence meant that there was a monitoring system in operation which offers review of, and support to, GPs' decisions. Similarly, it was seen as providing an important back-up in cases where GPs were uncertain or dubious about a patient's incapacity for work.

'I think the RMO helps an aw'ul lot, it makes it much easier ... it's a second opinion from somebody who does that sort of work. In a way, we're fairly isolated really. You'll probably find grossly different thresholds between GPs, I suppose, and the RMOs are somebody who will level things out.'

[Male, 7 years as GP, group practice (3), large city]

'This is where the RMO can be quite helpful. There are some people who come along regularly and you think that really they could be fit for work but you're not able to do it, because you're hack in this, "Oh, no, Doe, my back's playing up this week," or, you know, my ankle. It's always worse when they come to see you .... Then they go and have their assessment and it comes back saying this patient is fit for work. Now that's easy because you can confront the patient with that ....

[Female, 2 years as GP, group practice (7), large city]

'This is an independent assessment .... With your family doctor you obviously have to have a fairly reasonable relationship with the patient and it's of benefit to have the RMO to give a sort of unbiased independent assessment of a patient.'

[Male, 30+ years as GP, group practice (2), city]

quite a few times they [RMSJ have recalled somebody who's been off sick a long time who, I think, has got problems enough to justify keeping them on the sick .... They've gone to the RMO and they've come back with a letter - unfit to work, or incapable of work, which is reassuring. I think it is in that context I find them very useful.

[Male, 23 years as GP, single-handed practice, urban area]

Some GPs were also of the view that it was easier for someone independent to be 'tougher' in their decision about capacity for work, as they did not have to continue a relationship with the person.

7 think that it does make it easier for some patients to accept from an independent doctor rather than from their own family doctor .... I think it does help when it's a sort of an outsider, an objective outsider, whom they can't
actually get back to. You know, you have to continue seeing them for the rest of their lives ... For the minority of people who are sort of possible potential malingerers I think it is easier, not just from the point of view of the patient, but from the point of view of the doctor for them to be told by somebody who they won't meet again, that 'I'm sorry, you are fit for work'.

[Female, 7 years as GP, group practice (6), inner city area]

The importance of the Reference Service in the award of IVB was rarely questioned by GPs. But there were some widely differing views on the effectiveness and efficiency of the Service in performing its role. Some GPs were fairly critical of the service provided: others had mixed experiences or opinions; others were relatively full in their praise. Whether this is a result of differences between the regions in the operation of the service, or differences between the experiences of individual GPs, cannot be judged from this study. There were, however, a number of common features that formed the focus of comment.

Decisions about capacity for employment. There were differing views about whether the decisions coming from the Reference Service were 'too soft' or 'too hard' on the patients and whether or not this was changing. There were also varying comments about the apparent consistency or inconsistency of the judgements made. In these contexts, there were some comments about the basis on which decisions were made, given the relatively short contact that the examining medical officers had with patients during their examinations. From the GP's perspective, this could work either in favour of a patient - by being declared as 'unfit' when there were doubts about this --- or against a patient when there were factors that were not taken into account. In the latter cases, but rarely the former, the GPs 'overrule' the examining medical officers' judgements and continue to issue statements (see Section 5.2).

Notification of the decision. There were a number of comments about the content and delivery of the notifications of decisions received from the Reference Service. First, it was argued by some GPs that the reports should be fuller so that the GP - and the patient --- knew the basis on which a decision had been reached. A request for the identity of the examining medical officer to be disclosed was made. Second, some irritation was expressed at notifications that declared the patient to be 'fit for limited work'. These were sometimes accompanied by suggestions as to what the limited work might be (e.g. garage attendant, or cat' park attendant) which, in the GPs' views, were not particularly helpful.

'They usually j R. IS notifications] consist of a lot of ticks and percentages Welf, at the bottom line it says if they think they're fit for a sedentary job or something of that sort, or if they can use their arms or they can't use their legs that sort of thing .... If they think they're fit fi. r work then I'd like to know why they think they're fit for work ...

[Male. 30 years as GP, group practice (4). urban area]

'Where they re been assessed be the RMO and they come back with a whole lot of pieces of paper telling me that they can do so and so but they mustn't do so and so. And these are the ones where I have _yet to find that to be a realistic pragmatic option. It may be a theoretical one but there' Is no pragmatism about it .... The common one that I used to get is car park attendant .... I appreciate that someone who s been able to do a shovel job might possibly he able to kind of sit in a kiosk and collect money .... I've got about jive of my patients that do just that .... Car park attendant is the lowest denominator that anyone can envisage.'

[Male, 27 years as GP, group practice (2), urban area]

In a rather different dimension, some GPs felt aggrieved that they became the messenger of the medical officers' decisions. Although notifications are also sent to the claimant, it appears that GPs are sometimes the first to tell the patient that they have now been declared 'fit for work'.
I think that in the majority of cases the RMO has said nothing whatsoever tras the patient, and the first the patient knows of the RMO’s opinions that they should in fact go back to work is when they come to see me and they’ve been told to come to see me to discuss the results of the findings of the RAID. That is often a tricky time, because the form that I get back from the RHO gives true the option of overriding hint and saying that I disagree and it mat• well he that the patient knows that....

[Male. 19 years as GP, group practice (6). rural area]

**Relationship between the Reference Service and Employment Services.** The next chapter considers in detail the importance of effective services in helping IV.Fi claimants to re-enter suitable employment. There is a particular call for employment services to be strengthened to provide retraining and rehabilitation for people whose occupational potential has been affected by their illness or incapacity. This has implications well beyond the role of the Reference Service. Nevertheless examples were quoted which pertain specifically to medical officers’ decisions, where there appears to be no co-ordination between services. This can lead to difficult consequences for the GP.

_I think the RHO should tell the patient. They often don't. They just send us the bullets for° us to fire. We then send off the appropriate green piece of paper to say that this patient is fit to work within limits, and off they go to the disablement resettlement officer, and often they're thrown back again. Often the DRO trill sat', “It’s well, we haven’t got Lang; training for you; we haven’t got any Jobs for you. Go back to your doctor and get certified again.”_

[Male. 21 years as GP. single-handed practice. large city]

Other GPs argued that unless there is a more effective inter-relationship between the Reference Service and employment services, recommendations about limited work were on the whole rather meaningless.

**Speed of response.** Comments about the length of time that decisions from the Reference Service can take primarily concerned cases where the GI’s were themselves referring a patient.

_'If you’ve got people who have been off six, eight, ten months or whatever, if you feel they shouldn’t stay on the sick, or even people who have been off longer than that, what I think would he helpful is if we could bare an easier and speedier referral system for an R1110 to do an assessment.... I’ve referred people off by contacting [RMS office] and months have gone past.'_

[Male. 4 years as GI. group practice (6), large city]

Another GP from the same area commented on the importance of this for preventing ‘invalidity' from setting in.

_'It makes the situation worse because the longer the patient is made an invalid, the less likely they are to go back to work. It should be a much sharper system.’_

[Male. 21 years as GP, single-handed practice. large city]

Lest it be thought that this slowness of response was a local difficulty, similar comments came from GPs in four of the six regions covered by the study.

**Remoteness of the Service.** It was evident that many of the GPs saw the Reference Service as a remote and rather inaccessible service. Some of the older GPs commented on the noticeable changes there had been in this respect. In some cases, GPs said they did not know where the Reference Service was or who the medical officers were. It was also rare to find a GP who would readily pick up the phone if they wanted to discuss a particular patient or seek advice. The reasons for this included the time it takes finding the right person to speak to, the unavailability of medical officers, and not really knowing who or where to call.
Knowledge about the Service. As will be discussed in Section 5.3, it was clear that a number of the GPs were not using the Reference Service to its full potential. Part of the reason for this was a lack of knowledge and understanding of the way the Service works and the facilities it offers. Although some GPs were obviously very much in touch with the Reference Service and very familiar with its procedures, it was more common to find a vagueness or uncertainty about how the whole thing works. A number of GPs, for example, were puzzled as to the basis on which patients were called for examination. Similarly, some GPs openly acknowledged that they were not clear about the Reference Service and the facilities it offers GPs.

The GPs' lack of knowledge about the Reference Service can lead to misconceptions about how it works. There were, for example, GPs who believed that patients got seen 'automatically' so there was no real need for them to refer. There were other GPs who thought that any opinion about alternative work was for the Reference Service to decide, not the GP; or that any advice about training or employment rehabilitation must necessarily come from the Reference Service, again, not the GP. As a consequence some GPs are clearly reactive, rather than proactive, in their relationship to the Reference Service.

5.2 Responses to communications from the Reference Service

There are two types of communications that GPs will receive from the Reference Service. The first are requests for further information (RM2s) about the medical condition and history of individual patients. The second are notifications of opinions about patients who have been called for examination. The former always requires a response from the GP; the second asks GPs to consider the opinion and take action if they feel it is appropriate.

Requests for further information. GPs will be asked to provide further information about a patient when the local office refers a claimant for an assessment. If this information is not available to the Reference Service, it is likely that an examination of the claimant will take place. As a result, the Service is involved in some examinations that would not be necessary if fuller information about the patient was available.

The GPs were asked about the receipt of RM2s and what happened when they got them. Although practices varied, most of the doctors said they usually returned them reasonably quickly. Some said this was not a problem for them, either because they knew the patients well and therefore did not need to look up their records, or because the forms were 'straightforward' to complete. Others, however, were a little more critical of the time the forms took or 'the burden' they created. In the latter cases, GPs saw RM2s as yet more paperwork that they had to deal with in an already over-pressurised schedule. This could lead to a delay in returning the forms to the Reference Service.

The letter incorporated in Form RM2 explains that the patient has been referred to the Reference Service for an opinion on capacity for work. It then asks the GP to give 'any information which you think would be of help to the medical officer dealing with the case, should it be found necessary, judging from your report, to arrange for an examination.' Until recently, the form which GPs were asked to complete contained no specific questions about the patient's capacity for work but left a space for the doctor to give details of 'History and Present Condition'.

It was not possible to discuss in detail how GPs completed RM2s or what sort of information they recorded. However, two points were raised which may have a bearing on the medical evidence which GPs supply. First, there was uncertainty

1. A copy of the Form RM2 to which GPs referred is shown in Appendix 3.

2. A new version of the RM2 (see Appendix 3) has been introduced since this study was undertaken. This specifically asks GPs to comment on the ability of the patient to perform some form of work, now or in the near future,
from some GPs as to whether they gave sufficient detail on these forms for the purposes required. Second, there was a feeling among some GPs that they were being asked to write reports for patients who were so clearly incapacitated that it was a waste of time for them to do so.

"They're asked for a report on a 64-year-old ..., That irritates me a little hit when just by looking at what the problem is and just by looking at the age of the patient and the starting of the sickness, it is quite clear that there's no real value to anyone even if he was fit for work. You know, it is such a short period of time that it really wasn't worth all the trouble they went to.'

|Male, 5 years as GP, group practice (5), urban area|

Notification of opinions. When a claimant has been called before the Reference Service for assessment, a notification of the examining medical officers' opinion is sent to the claimant's GP. If the Reference Service doctor agrees that the patient is incapable of work, the GP will continue to issue statements as they judge appropriate. If, however, the medical officer assesses the patient to be capable of their usual occupation, or capable of alternative work within certain limits, the GP must consider whether they agree or disagree with this opinion. If they agree, they will issue a 'closed' statement which will terminate IV13. If they disagree, they can continue to issue statements and the patient's case will then go for adjudication. As part of this process, another medical examination, with a different doctor from the Reference Service, will usually take place.

Most of the GPs interviewed said that they usually went along with the medical officers' opinions or that it was rare for them to disagree. Certainly, there were few GPs who could remember more than one or two cases where this had happened. Sometimes this compliance was almost a matter of principle, but in most cases it was because they had no reason to disagree. In the few cases where they had done so, it was usually because the GP felt that the examining medical officer had been too harsh on the patient. In such circumstances, most of the GPs continued to sign statements for the patient.

"... he got passed for light work with the suggestion being he got a job as a car park attendant ... which, you know, I thought was impractical and insensitive .... The chances of him getting a kind of job like that were nonexistent .... A chap in his late 50s who has had an excellent work record all his lie, the implication was that he was skiving ... he was only packing in work because he had a number of quite troublesome medical conditions.'

|Male, 17 years as GP, group practice (4), suburban area|

Disagreement usually occurred because GPs felt that there were factors that the RMS had not taken into account in their assessments; or because they firmly believed that a return to work, or to unemployment, would have detrimental consequences for their patient's health.

"It is this chap who's had the leg injury -- I don't think the RMS had sufficient information about this condition that the patient had, which is a very strange, old condition .... When the RM saw this chap, he said he was fit to go back to work, but in fact I know that each time he tried to go back to work his
injury recurred ... so I did write to the RMO and explain ... I’m carrying on signing for the time being.’

[Female. 6 years as GP, group practice (5), rural area]

It was rare to find a GP that attempted any dialogue or communication with the Reference Service about a decision, as in the above case. Certainly it was exceptional to find a GP who attempted to phone an examining officer about a decision.

The GPs were asked if they knew what happened if they continued to sign statements for a patient who had been declared fit for work by the Reference Service. Some knew broadly about the adjudication procedures, rather more were fairly hazy about what happened.

‘I just carry on giving the sick notes .... One of two things happen. One is that the Department of Social Security just carry on as they are, or they arrange for someone else to do an assessment or maybe even the same RMO. I don’t know how they work out who does the second assessment. I’d like to know actually, but then the second assessment is done, and then you get a stronger letter telling you what they feel should be done and if the second assessment is the same as the first, there’s a lot of clout to make you change. If you don’t change and you keep on giving the sick notes, I think - I’ve never been in this situation - but I think they have a third assessment, ... and that determines what happens. But I don’t know what happens at the end of the day if it comes to the final crunch - whether the Department of Social Security can say, “No, we’re overriding what your doctor’s doing.” I don’t know if they can do that.’

[Male. 4 years as GP. group practice (6). large city]

‘They’re reviewed again, you know, and I think it gets steeper, more and more difficult .... I mean, it hasn’t happened to me because I haven’t really had a dispute with them about it, but I can imagine what would happen. I could carry on signing certificates to say that they are incapable of work and after a period we would start getting letters from the RMO sort of querying this and even an interview to discuss it. but I haven’t been down that road so I don’t know.

[Male. 23 years as GP. single-handed practice, rural area]

5.3 Use of the Reference Service for advice or second opinion

The GPs are advised that:

If you want a second opinion while continuing to issue statements to your patients, you may refer the case to the appropriate Senior/Regional Medical Officer direct, using form RM7, one copy of which is included in each pad of forms Decl3. The local Social Security office will be informed of the result of the examination and action will be taken in exactly the same way as if the claimant had been referred by that office. Local Social Security officers and doctors at the RMS who examine claimants will not divulge the source of the reference.’

[Guide for Registered Medical Practitioners, Section 12]

in general, the GPs made very limited use of referral to the Reference Service for a second opinion. Some GPs said they had never referred a patient. Others said it was rare for them to do so. Even those who were most positive about the value of the referral system, made relatively infrequent use of it. Yet, as will be apparent from previous chapters, all of them had some patients for whom they were currently signing statements where they felt their decision about the patient’s incapacity for work was uncertain. Why, then, did referral not more commonly occur?

‘I’ve not done that, no .... The RMO seems to see them all after about six months on I S.

[Male. 4 years as GP. single-handed practice, large city]
"They" tend to call people up themselves, and I suppose I don't tend to refer unless there's a particularly difficult one that I'm not happy about. They tend to call up most of the ones that I wouldn't be happy about anyway. I think these have a sort of nay of knowing.'

[Female, 4 years as GP, group practice (2), rural area]

'I haven't referred directly ... I've never done that ... Fin not sure really, I think in a way - it's difficult to say to a patient at any one time, "Well I'm not I'm not very happy with the way things are going. "' You know, one tends to use hospital services for these kinds of decisions.'

[Female, 13 years as GP, group practice (3), inner city area]

If I be interested to know if doctors do use that RM7. I can't remember ever having used it ... honestly, I can't see what good its going to do. That's the reason. And I think that really it's a deceit on the patient, because after all they are your patients: they come to you; you have to try and work with them. If you go around behind their back and say you think they're skiving and call the rest of it - however difficult it is - you have to try and say it to them if you feel like that .... To say it to somebody else who's not on their side, I think that's a hard thing for a personal doctor ... and it's an irrelevance, really. It doesn't serve any purpose as a rule .... If that was the way to get them back into employment there would be some purpose, but it simply isn't so.'

[Male, 30+ years as GP, group practice (3), inner city area]

As will be seen, some of the reasons are relatively straightforward and relate to the GP's lack of knowledge of the Reference Service system and how it works. But there is also what appears to be a reluctance to act in a way that is going behind the patient's back - or that is not in their patient's interests. This reluctance exists partly because of the very same factors that make decisions about capacity for employment difficult in the first place. It also arises because of a potential betrayal of the doctor-patient relationship. Once again, the essential conflict that GPs feel between their role as doctor, and their role as a 'keeper' of a state benefit, begin to surface. This will be fully explored in the next chapter.

The GP cited above was not alone in saying that she would refer to a specialist or to hospital services if she was doubtful about a patient's progress. However, it is a little puzzling as to why, since GPs generally of the view that specialists were not that effective in judging capacity for employment. other than in clear cut cases. Where there was any dilemma, or where factors other than medical considerations were taken into account, the hospital services would not necessarily know the patient's full circumstances.

The use of the form RM7 was variable. Some GPs always used it whenever they referred a patient. Others said they never used it either because they never referred patients or because they preferred other means of requesting a second opinion. These other means included writing letters or writing 'RMO' on the medical statement. A few GPs had more covert ways of signalling uncertainty through the Med3. either by writing vague diagnoses or changing statement periods.

The GPs were more or less evenly divided between those who always or occasionally used the RM7 and those who said they never did. The latter group had some difficulty explaining why not. although some were clearly unfamiliar with the form or where to find it.

For those who gave an explanation_ there seemed to be three reasons why the RM 7 was not used The first concerned administrative ease in that it was simpler to use other means. The second related to the confidential nature of the RM7 and the implications this had. The third was related to more fundamental issues concerning the whole process of GP referral to the Reference Service, as discussed above.

3. A copy of the RM7 is shown in Appendix 3.
A central issue that emerges in the context of GP referrals is the openness which GPs want to have with their patients. As will be evident from the above descriptions, some GPs hold a strong view that if they are going to refer the patient, they want them to know this is happening. This in itself can be a reason for not using the RM7, which is a confidential report. Others hold a quite opposite view that they do not want their patients to know that they have been responsible for the patient being called before the Reference Service. For the former cases, there would be value in having some means of recording on the Med3 that a second opinion would be helpful. Whether this would be seen as sufficiently neutral for those who would prefer their patients not to know is difficult to gauge.

5.4 Suggested changes to the operation and procedures of the Reference Service

The preceding discussion suggests some possible ways in which the Reference Service could further aid and support GPs in their decisions about issuing statements for IVB. GPs also had specific recommendations to make about ways in which the Service could improve or change its methods of operation.

Greater knowledge of the Reference Service and its procedures

The role and operation of the Reference Service forms part of the extended knowledge base that GPs need to acquire. Ways in which this might be developed are discussed in Chapter 7. The specific requirements, however, are for more information about who is selected for reference and on what basis, how the RM2 is used, how GPs should refer and what happens when they do, how examining officers' recommendations about employment options for claimants now operate and the Service's role in adjudication.

Greater accessibility

Some, although not all, GPs said they would welcome a point of contact within the Reference Service with whom they could discuss problems or from whom they could get further information. Others held a more general view that the Reference Service should become less remote than at present. Particular requests were made for local contacts and for named medical officers to talk to.

It should be noted that there were some GPs who were not in favour of having closer contact with the Reference Service in this way. This was because they felt it important to maintain their independence from the DSS and hence from the Reference Service as well.

Changes to procedures for seeking a second opinion

Suggestions were made about methods for obtaining a second opinion from the Reference Service in cases where there is uncertainty about capacity for work. In some cases GPs suggested that they would like the opportunity to discuss their difficulties before anything more formal happened. Others suggested that the mechanism for referral should be changed. Certainly the previous section suggests that current procedures, through the use of the RM7, are not operating very satisfactorily. This led to a suggestion that there should be some more easily available - and open - mechanism for referral, possibly on the Med3 itself.

Speedier response to GP referral

As was described earlier there were persistent complaints from GPs about the slowness of response from the Reference Service when they referred patients for assessment. Part of the reason for this may lie in the methods that GPs are using to signal or flag a request for referral. Nevertheless, there were also complaints from GPs who had used RM7s. GPs see this as particularly frustrating when the receipt of IVB is in its early stages.

Changes to notifications of medical officers' opinions

Two specific suggestions arise in this context. First, some GPs would like a little more information about what factors have influenced a decision to judge a patient capable of work or 'fit within limits'. Second, there are clearly problems arising through GPs finding themselves being the first to tell the patient that the examining medical officer is of the opinion that they are now 'fit for work'. This led some GPs to say that the examining officers should tell the patients themselves, rather than leave it to the GPs. Alternatively, there may need to be some review of how communication between the Reference Service, the local office and the claimants is currently operating.
A matter of deep frustration to GPs is the lack of communication that appears to exist between the DSS and the Disablement Resettlement Service or employment services more generally. This issue arises in the context of the Reference Service when recommendations for either rehabilitative training or limited work are made. For reasons previously discussed, GPs were of the view that when such recommendations are made they must be backed by some employment action. Otherwise, everyone in the system - the patient, the GP, the local office, the Reference Service, the Employment Service - appears to be wasting their time.

Many of the GPs were of the view that the Reference Service should play a more powerful role in the award of IVB, thus taking some of the weight from GPs’ shoulders. This is considered more fully in the next chapter where the broader issue of how the GP’s role in the award of IVB is reviewed.
6.1 GPs views about their role

GPs were of common voice in the difficulties they described about the award of IVB. But there were some clear differences between them in how they felt about carrying the responsibilities they have. Some saw it as an inevitable element of their job or were simply resigned to the fact they had to do it. Others saw it as rather more of a burden, at least part of which they would like lifted. Yet others saw it as a major interference in their role as a doctor and would like the whole thing taken out of their hands.

‘I think it's part of the job ... its part of treating medical conditions. If someone needs rest you would quite happily recommend rest. So the next logical step is to give them a little bit of paper saying that it's valid for them to rest, you know. I can't see that you can really separate the two .... I don't find it bothers me too much, maybe it should, you know, it doesn't really worry me too much.’

[Male, 17 years as GP, group practice (4), suburban area]

"Somebody's got to decide whether people are fit to work or not ... who else could know, who else could do it ... , because the GP knows more about the medical history of the patient than anybody else and he knows the patient well. He's the only medical person that knows the patient well."

[Male. 17 years as GP, group practice (6), rural area]

... you're ultimately deciding whether someone's going to get some money or something, there’s a finance involved and that makes a big difference to a relationship and it's better, in many ways, if there's someone, an independent person, a third person, because we can then support them in whatever problems that they have. If the patient feels, perhaps quite wrongly, that they're not getting their money because I say they're not getting it, its very difficult .... I do take it quite seriously and do my best - I tend not to want to abuse it, but I do wish it didn't actually rest with us. I think it's probably inappropriate for it to rest on us .... It can create a number of pressures. It's also a lot of wasted consultations giving out certificates,'

[Female, 12 years as GP, group practice (5). urban area]

I think doctors generally would rather not do certification for sickness. It's a job that we are not trained to do. I'm trained to diagnose things and to treat them. I'm not trained to tell people if they are fit to work or not and I think that doctors, not detest doing, but it's something that they don't like doing because it then puts us in a difficult position with our patients ... because we are deciding their financial wellbeing .... If I didn't issue any certificates at all, then ... I would just be treating their illness and trying to overcome their illness rather than having this, being manipulated really .... We could discuss the management of their illness. They wouldn't have to convince me how tired they felt and this is the problem - that it affects our consultation. Our relationship is affected because we have this power to give them a certificate or not give them a certificate .... If that was totally removed from us, I think that would improve our relationship with patients .... I think you'll find that,
for most GPs, it's one of the most unpleasant parts of our job .... I'd rather face nasty abscesses than actively confront a patient with their invalidity benefit,' [Male, 17 years as GP, single-handed practice, rural area]

The GPs were asked to consider whether there were any ways in which their role in the award of IVB could be changed. There were three levels of response to this. First there was a widespread view that there needed to be some change concerning mechanisms for assessing capacity for employment. As was made very clear in Chapter 4, GPs are not generally comfortable about their ability to assess capacity, particularly where alternative work or retraining is in question. There were various solutions to this which ranged from having this function transferred to some independent qualified assessors through to extensions of the current Reference Service procedures. These are discussed below.

Second, there were GPs who wanted to somehow disengage any medical assessment from the consequences for receiving benefits. As is evident in the accounts above, it is this that lies at the heart of many of the dilemmas that GPs experience because it produces a conflict in the responsibilities they feel for their patients. Again some suggestions were made as to ways in which the system might be changed (see Section 6.4).

At the third, and more global level, GPs were concerned about the practicality of the solutions they may have offered. They could see, for example, that there were particular groups of patients on IVB where the GP could quite clearly and confidently judge capacity. These presented no difficulty and it would be wasteful for anyone else to become involved. In addition, several GPs raised the point that they, more than anyone else, knew their patients' medical conditions and histories. This made them wonder as to how effectively an outsider might be able to judge the situation. Similarly, they could foresee that any independent assessment or self-reported assessment would inevitably be reliant on some medical reports from them, which would begin to draw them back into the same set of judgements.

As a result of all these considerations there were few GPs who concluded that there was a clear cut case for the GP's role in the award of IVB to be removed completely. Nevertheless there were many suggestions as to how they might be aided or supported in this role. Before these are considered, it is important to understand the conflicts of interest that GPs experience in being involved in state benefit provision. As GPs were at pains to point out, if they are to have a role in the award of IVB, then certain constraints on their performance will have to be understood. All these revolve around the other responsibilities that GPs have in providing appropriate health care for their patients.

6.2 The doctor - patient relationship and other conflicting interests

In the course of the interviews there was not a single GP who did not raise the issue of the doctor - patient relationship. It was this, almost more than anything else, that could sway a GP to sign a statement in cases when there was any doubt. It is therefore important to consider what this relationship is about and why it is so influential in affecting decisions.

One thing you have to appreciate is that there is something called a doctor - patient relationship and just because of a certificate you don't want it to break down .... To write a certificate is easy and to deny it also is very easy, but one has to be considerate of the other side as well - that patient's side. Because there are some patients who think they've got a problem and they don't want to work, or can't go to work, and you have got to get a compromise and get the best out of them as well.' [Male, 3 years as GP, group practice (3), inner city area]

It's very difficult to define the doctor - patient relationship; there are so many variables that go into it. There's a patient dependence on their doctor and a
patient colluding with their doctor, I suppose. You're there for their physical health; you are there to do everything you can -- this is the patient's viewpoint; you can make them physically better. More and more patients are seeking your help for their social problems, which didn't happen, from what I've heard from my partners anyway, 20 or 30 years ago ... I suppose there's the aspect that the doctor doesn't want to make the patients go away thinking, she didn't do anything for me. It matters if the relationship breaks down because that's not beneficial to either the patient or yourself ....

[Female, 2 years as GP, group practice (7), large city]

Welk it's rather like you having friends. You develop a relationship with a friend and you feel good about that .... The deeper the relationship develops, the more you feel free to go and talk to that person about it .... A doctor-patient relationship is in a way a similar sort of relationship .... It's nice to make people feel at ease, to be able to come and talk to you about whatever they feel they want to talk to you about, because general practice isn't just about dealing with physical ailments. It's about, as well as looking after the physical component things, you've got also the social and psychological aspect of things and you've got to address all three areas, really.'

[Male, 4 years as GP, group practice (3), large city]

'It's not easy to define .... When you look at the doctor-patient relationship you are talking about a relationship of which there are many, many facets ... one person with specialist expertise being consulted by another .... It will never be completely equal, even if you operate from the model of adult to adult, because as a doctor I have certain specialist information so, as the patient, you are coming in in need of help. But, to go beyond that, it can also be understood in psychotherapeutic terms .... The best analysis of this is that the most important tool in general practice is consultation and the most important drug is the doctor - and it's this interface between the doctor and the patient .... You're dealing with a whole person in body, mind and spirit and that is why, as a patient, you bring when you sit in a chair.

[Female, 8 years as GP, single-handed practice, rural area]

On one level it appears that the relationship is rather one-sided in that its main features rest largely on a trust that patients place in their doctors. This is to provide care for both physical and psychological needs, offer support in times of social crisis or adversity, and generally act in their best interests. The trade-off for GPs appears to be that acceptance of this trust will afford the best conditions in which to provide consultations. Hence they achieve a primary goal of providing the most effective care and treatment of their patients. In the course of so doing, they will retain their patients' good will and continuation as a patient.

This oversimplified and somewhat clinical description does little justice to the feeling with which the doctor-patient relationship was described. Indeed, GPs had much to say on the subject and often described it as 'difficult to define' or 'multifaceted' as in the accounts above. From the GPs' perspective it clearly contains elements of being a friend, counsellor, advocate, mentor, pastor, therapist and healer, and much more could be said about the nature of the relationship. But for the purpose of this study, the key question is why it is so relevant to the GP in their role of issuing statements for IVB.

The answer to this appears to have two parts. First, the very process of assessing capability for work and then issuing statements is based heavily on what patients tell a GP. In cases where there is any uncertainty, the GP is almost forced to call the patient's evidence into question. This undermines the 'trust' that is inherent in the relationship and can cause the GP to challenge or confront their patient, both of which are harmful to the relationship.

Second, there were concerns about confrontation with patients. This was another subject on which the GPs had a lot to say. In general, they wanted to dispel
confrontation in their consultations because it affected the way they could treat patients. Because it caused aggravation, because they personally disliked being confrontational with anyone and because it could lead to a complete breakdown of the doctor-patient relationship.

It's very difficult for a doctor in a relationship where you're not necessarily challenging patients. You're believing what they say, you're trying to help them... It's difficult to challenge them on that, to openly say, "Well, do you really want to work?"... I think people lose confidence in you a bit... It's just the thought that you might alienate the patient and as I say in the therapeutic relationship, you're not often challenging with people.'

[Female. 12 years as GP, group practice (5), urban area]

'I wouldn't embark on a pointless confrontation... I think you've got to listen to people and largely accept what they are telling you, and if you start to argue with patients because you know they're swinging the lead or whatever, it doesn't gain you an alliance, and I also think it impairs your treatment of patients you see in the same surgery... I don't think it's fair for the vast majority of genuine people for them to come in and see a frustrated, angry, cross GP who has been wound up by someone coming in before them.'

[Male, 17 years as GP, group practice (4), suburban area]

If the doctor-patient relationship does break down, one of two things may happen. Either, the patient will continue consulting the GP but in an atmosphere which does not serve to provide good treatment; or, and this appears to be the more common outcome, the patient will move to another GP in the practice or leave the practice list altogether.

'It [the relationship] could break down - basically I don't think I'd see that patient as often. I think this is basically what I'm afraid of -- that I wouldn't see that patient as often, and if he did have the kind of problems I've just mentioned - around difficult kind of personal and family problems -- he wouldn't feel in a position to be able to see me about that. That's a real fear - that I would close the door to him for those kind of problems...'

[Male. 9 years as GP, group practice (2), suburban area]

'It's the falling out with patients... I had this patient; I didn't sign his statement. And what did he do? He left my list. So, if I said to them, "Right, I'm not signing any more," they'd go down the road, see another doctor and get a sick note.'

[Male, 17 years as GP, single-handed practice, rural area]

A common feature in the GPs' descriptions of their relationships with patients was the need to respond to psychological as well as physical needs. This also has considerable relevance to the award of IVB. If a GP takes action which is against the patient's wishes then, almost by definition, additional stress will be placed on the patient. This has a considerable bearing on discontinuing statements and returning patients to unemployment or to work they are not motivated to do. Similarly, many GPs believe that in the current 'economic climate' it is simply not in their patients' best interests to make them face stress of this kind, and hence they continue certification, with or without pressure from the patients.

6.3 'Certain' and 'uncertain' decisions

The GPs identified a number of circumstances in which they felt their decisions about TVB were uncertain. These all surround the 'problem' patients or the 'difficult' conditions and a great deal of time was spent discussing them. But, in placing the spotlight entirely on these groups, there is a danger that those who present no difficulties to GPs will be forgotten. It is therefore essential that some analysis should be made of the levels of certainty or uncertainty that surround IVB patients as a whole.
The level of certainty surrounding IV.B certification can be broadly placed in four categories:

**Certain** because of the nature of the condition, the impairment it causes or the disablement it creates

**Legitimate** because the *nature* of the condition combined with other factors, such as age, or employment potential, would make it unjustly punitive to the patient not to issue a statement

**Uncertain** because of the multiple factors that have to be taken into account and their interaction

**Illegitimate** because the GP recognises that *they* are being *manipulated* by the patient or are *bowing* under pressures from them.

It would be imprudent for this research to attempt to place any estimates on the size of these groups. As has been shown, GPs are not well placed to be categorical about numbers and no systematic account of these different groups took place. More crucially, it would be dangerous to attempt any estimates simply from GPs impressions. This is because the latter two categories, whatever their size are requiring the majority of effort and attention. The former two categories pose virtually no dilemma at all and they assume much less significance in the GP’s mind. However, what should be reported is that the illegitimate* category, according to GPs, is only a ‘*small minority* of their patients. The uncertain category is, without question, much larger.

GPs’ accounts of the patients that present most uncertainty to them centre on the following groups:

- patients with conditions which are **difficult to diagnose**, or detect

- patients with **associated psychological stress-related or drug/alcohol dependency problems**

- **Younger patients**, because of the dangers of becoming permanently incapacitated from work

- patients who are **unable to cope with their condition** or become invalids’ unnecessarily

- patients who are **unable to ‘cope’ with life’s demands** more generally

- **Inherited patients** u.ho have moved from another practice or another GP’s list.

Some specific accounts will help to illustrate:

*The younger the age of the patient ... because if one signs them off for longer periods when they’re young, one has to be really fairly sure that their medical condition is going to continue as such or deteriorate or improve, particularly, if we’ve been giving them longer-term sickness certificates ... One chap [in his late 30s], where I’ve been in a quandary, and I’ve just been giving him certificates for a month at a tune and he was getting terribly cross about this, but I was concerned that he shouldn’t have longer-term sickness certificates.*

[Female, 13 years as GP, group practice (3), inner city area]

*You see, *not black and white. *You can’t just suddenly say there comes a cut off point .... The typical complaints are where you have to rely on the history of the patient’s input to determine the severity of the disease and anybody who is clever enough or been around long enough in the game .... The
doctor has to give the benefit of the doubt in such cases, you know, backs must be notorious.'

[Male. 30+ years as GP, group practice (4), urban area]

'A again, you see, nothing is ever clear cut in life and especially in medicine because medicine's about life really. There's a woman who comes in here has been complaining about her back for more than a decade ... and she always comes in with great drama ... so therefore you can say, "Right. this hack pain is somewhat overplayed," but you still can't prove that they haven't got back pain .... And then you ask yourself why, why are they overplaying it? And in the case of this woman, she's depressed .... She's a newish patient to me ... and I've started treating her for depression, so the fact that her back pain is overplayed does not mean that she is fit for work .... '

[Male, 11 years as GP. single-handed practice, inner city area]

'Perhaps I should say to him [nude patient], "I totally refuse to sign sick notes; you are fit for work. " but he'll go down to the office and won't be able to do heavy lifting and he won't be able to do this, and he won't be able to do that, and they'll send him back to me saying he needs a sick note because he's not fit for the jobs they offer him .... But I find it very hard to challenge him, to say, "You're not trying hard enough. " There's not many of them, but I do find it very hard to challenge him. I don't think you should make that decision for him.

[Female. 1 8 years as GP, group practice (5), large city]

6.4 Aiding GPs in their role

The final section of this chapter considers ways in which GPs can be helped with the difficulties they face in issuing statements for IVB. They all relate to actions which other agencies need to take, and in particular the DSS. Actions surrounding the need for further education and guidance of GPs are considered separately in the final chapter.

The Social Security system and procedures

As was discussed earlier, there are some GPs who want their role in the award of IVB removed completely. In most cases they felt the issue of statements for sickness benefit should stay with them, but that there should be some change when invalidity benefit begins. The most significant change wanted was that the GP's role should be confined to confirming the medical condition alone, but should not be the sole mechanism for award of the benefit. Two possibilities suggested were:

- that the DSS acts as the final arbiter of the benefit award, rather than it being solely dependent on the doctor's statement
- that patients self-certificate, as is now operating for Disability Living Allowance (DLA), or Disability Working Allowance (DWA), with confirmation of the condition from the GP.

Replacement of GPs in the award of benefit

The call for the role of the Reference Service to be strengthened was widespread amongst the GPs interviewed. Virtually every GP made some kind of request for greater intervention by opportunity of referral to, or support from, the medical service.
As was noted earlier, some of the suggestions made are already in place but GPs were not using the Service effectively. The recommendations made in Chapter 5 would all be of benefit in this context. However, it is also clear that some of the help wanted from the Reference Service goes beyond the service offered as it now operates. Suggestions were made for:

- a systematic assessment of all claimants, either just before or in the early stages of receiving IVB, with notifications to GPs
- an assessment of all claimants after they have been on IVB for a given period (e.g. 12 - 18 months), with notifications to GPs
- assessment of alternative occupation or employment rehabilitation to be exclusively in the hands of the Reference Service
- assessment of the more `difficult' cases for decision by the Reference Service.

Implicit in many of the suggestions was that the role of giving `opinions' about capacity for work, should be changed to giving `decisions'. Some GPs currently believe this is what happens, even though they know they can disagree. More fundamentally, GPs, in the main, do not want to be the ones to act as the decision-makers, particularly in more difficult cases.

The role of local social security offices

A bad experience in communications with local offices is likely to be a major irritant to GPs who are already feeling a little brittle about their role. In this context, a local office suggesting to a claimant that they go to, or go back to, the doctor to get a medical statement is the source of some wrath against them. Similarly GPs get very cross about inefficiency in terms of lost statements or the lack of response to communications. Also, as already noted. GPs do not expect to have to deliver the DSS's `decisions' for them in terms of a judged capacity for work.

Employment programmes and services

There are a number of levels on which the performance of employment services can affect a GP in the award of IVB. At the most general - even political -- level it is clear that GPs are affected by high levels of unemployment and what was constantly referred to as `the recession'. More specifically, most of the GPs interviewed had a very poor regard of employment training and of the services offered by the Disablement Resettlement Service. There were many examples cited of patients who wanted to work - and could work within limits -- but who were denied any opportunity for either employment rehabilitation or open or sheltered employment opportunities. In the face of such factors, GPs feel wholly legitimised in issuing statements for IVB.

As was previously discussed, there is also a problem about referral between services. It is not clear to GPs what happens to activate employment services when the Reference Service recommends limited work or rehabilitative training. But what incenses GPs most is when patients have been referred for employment counselling or training of some kind and are then referred back to the GP - by the very same services that are meant to be providing employment action. As GPs see it, it compromises their decisions, disheartens the patients and leaves everyone disillusioned about the effectiveness of state services.

Health services

The help that the health service can give GPs in their role in IVB is more specific. First, a number of GPs commented on the length of time that patients were waiting for treatment or operations. Because of concerns about the effects of absence from employment, this can have a detrimental effect on a patient's prospects of return to work. Second, some GPs are of the view that the nature of the patient's problems is one that requires counselling or therapeutic services. Some GPs themselves feel able to give this; others feel it needs specialised services. The value of counsellors, which some practices used, was noted in this context.

The suggestions in this section have come directly from GPs without comment on how realistic they may be. This is for the DSS and the other relevant departments.
to consider. However, it is abundantly clear that GPs need some help - they are often isolated in their decisions, have little feedback on their statementing practices, and feel inadequately equipped to make some of the judgements required. Given the importance of their role in the award of a benefit which is of such concern in terms of its costs, it is clear that some review of the system is required. It does, however, need to be accompanied by a programme of information and education for GPs as is described in the last chapter.
It has been clear throughout this report that GP's knowledge about the requirements and procedures for the award of IVB is patchy if not poor. The GPs themselves are the first to admit this. This final chapter briefly reviews the information that GPs need to acquire and then considers some possible ways in which this might be achieved.

7A The information required

**Knowledge**

There are four key areas in which GPs need to extend their knowledge base:

*local office procedures for review and control of IVB claims,* and in particular how medical statements are used for these purposes

*the Reference Service,* how it operates and the criteria used for assessment and examination

*procedures and actions that follow disagreement* between a GP and an examining officer over an assessment of capacity for work

*mechanisms for referral for employment or training assessment,* both between the Reference Service and the employment services, and for direct referral by GPs.

These are in addition to some refreshment of the basic conditions for the award of and, in particular, differences between conditions for short-term sickness benefits and IV13.

**Guidance**

The key area in which GPs need guidance is in assessing capability for work. In particular, they need considerably more advice about:

* how to balance the varying factors they take into account in judging capacity and whether or not they are appropriate
* the circumstances in which referral for training or rehabilitation assessment are appropriate
* how the potential for alternative work should be judged.

**Information**

There are two rather different dimensions which GPs need further information to fulfil their role in the award of IVB. These concern:

* the transition point to IVB for individual patients
* feedback on their own 'performance' in issuing statements for IVB.

The GPs' need for knowledge in the above areas has been fully discussed in previous chapters, particularly in Chapters 3, 4 and 5.
7.2 Methods of extending the GPs knowledge base

Written guidance

The Guide for Registered Medical Practitioners, which has been regularly referred to in this report, was recently updated and sent to all GPs in April 1991. Although most GPs were aware, even if only vaguely, of its existence, only some had read it - usually when it first came out - and few used it for reference. Most of them had `filed it somewhere' or admitted it was `gathering dust':

‘When this book came out, this medical evidence, this guide ... I said, "Oh good," and I read it, but I didn't read it - I started to read it and it's the kind of thing that you keep in your room. I must read that thoroughly some time .... I suspect that it hasn't been read by a lot of doctors.'
[Male. 9 years as GP, group practice (2). suburban area]

The reasons for the very limited use of the booklet appeared to be threefold:

• pressures of time, particularly as GPs have other important reading they have to do to keep up-to-date with their work
• no perceived value in reading it since it was only there for reference, or they never had occasion to use it
• particular criticisms of its content (not specific enough) or its style of presentation (vague. not easy to access information).

'It's quite helpful. It's not terribly digestible - the information doesn't leap out
It's very didactic. You've got to hunt through to find the hit you need .... It's all there, but it's not terribly easy to pick it out .... I think the honest answer is that I probably haven't read through this. Perhaps I should have done. I tended to browse through it, but it's like with a lot of doctors, when things come through the post, they either get thrown in the bin or filed away to be looked at later,'
[Female, 12 years as GP, group practice (5), urban area]

The GPs use of the existing Guide suggests that there may need to be some radical change in the way in which written guidance is issued to GPs. First, GPs are going to have to be alerted to the importance of reading the material if it is to convey new messages or raise consciousness. Second, if it is intended to be used for reference, then it may need to be more specifically designed for this purpose.

Although there will be a need for some kind of booklet, some thought might be given to other means of conveying guidance to GPs. For example, most GPs now have computers on their desk and some form of computer information package might be designed. GPs also spend a great deal of time driving round in their cars so audio tapes are another possibility. These suggestions are in keeping with recommendations from other research on access to benefit information.

Training and education

A number of the GPs commented that they received no real education in what is involved in the award of [VB. At undergraduate level, they received minimal education about their role in awarding benefits, and issues like judging capacity for employment were rarely addressed. This led some GPs to suggest that there should be greater coverage of these matters on undergraduate courses.

Several of the GPs were of the view that there needed to be more extensive training in incapacity benefits for doctors in general practice. The idea of regional seminars was put to them as one possible solution There was considerable enthusiasm from some. a more muted response from others and one or two of the oldest GPs said it was now too late for them to learn. Whatever their view, however, there were some important qualifications surrounding possible attendance. The main requirements were that it should be locally based and at times that GPs can realistically manage. It was also felt by some that the 'training' should be run by local postgraduate centres and credited towards postgraduate education.
GPs now have to involve themselves in a certain amount of postgraduate education per year - they have to do that to draw a postgraduate training allowance. They have to attend these, so if such a seminar was accredited for that, I would be much more likely to go.'

[Male, 19 years as GP, group practice (6), rural area]

Sources of advice

In addition to some general training in the issues listed above, the major call from GPs is for sources of advice about particular patients. These were of the kind described in the previous section and will not be repeated here. However, it must be stressed that, at present, it is rare for GPs to seek advice from the Reference Service or the local office, and exceptional for them to consult employment services. They are much more likely to seek a second opinion from a specialist or, more infrequently, from a colleague in their practice.

Notifications to GPs

It seems unlikely that GPs will know of a patient's entry, or potential entry, to IVB unless something or someone alerts them. As was discussed in Chapter 3, they become aware either because the patients tell them or because RM2s start coming through. If it is felt to be important that GPs know about the entry point, then there needs to be some procedure for notification from local offices. This possibility was not discussed with GPs although it would certainly be welcomed by some as a mechanism for discussion with the patients. It would also serve to remind the GP that the basis of judging incapacity after entry to IVB should be broadened.

There are also suggestions to be made surrounding the notifications that are currently sent to GPs through the Reference Service. It has already been noted that GPs may need more guidance about what to write on an RM2, and would like fuller information about the basis of Reference Service assessments of patients judged fit for work. In both cases, the provision of fuller information would help to extend GPs’ knowledge of the factors that are being taken into account. It will also help them to take necessary action in the case of individual patients, as was previously described.

Feedback on judgements

At present, the only feedback that GPs have on their decisions about IVB are when patients are sent to the Reference Service for a second opinion. As was shown in Chapter 5, the extent to which the Reference Service supports their judgements is one of the ways in which they know that they are working within appropriate boundaries. Some of the GPs spontaneously suggested that they would welcome some feedback on their statementing practice. Although it is difficult to see how this might work from an administrative point of view, there are some GPs who would like to know whether they issue relatively high or low numbers of statements for IVB and whether their judgements are viewed as too lenient or otherwise.

From the evidence collected, there is little doubt that the GPs’ knowledge of their role in the award of IVB needs to be extended. The suggestions above are just some possibilities for how this might be implemented. However, it is vital to stress again that the difficulties that GPs face will not be solved simply by information. There need to be accompanying changes of the kind suggested in the previous chapter. Perhaps more significantly, if GPs are to retain their full role in the award of IVB then it seems it will be operated within the parameters that are acceptable to them in their wider role of family practitioners.

I feel that certification can be a problem between patients and doctors, and that my duty as a doctor is to look after the patient and to be an advocate on their behalf to get them better health if I can. And this has got nothing whatsoever to do with obtaining sickness benefit for them. This is a barrier that comes between the doctor and the patient in getting them better as far as illness is concerned, and causes a breach of trust and is a problem, and is an

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1. The question about ability for work, which is incorporated in the new version of the RM2, will help to provide such guidance.
irritant as well .... It is totally impossible to make the government or anyone else understand that our interest is solely in the patient and that my interest, if you were a patient, would be solely in dealing with you as long as you're sitting across the desk from me. And when the next patient comes in, my interest is solely with that patient .... Therefore I find it deeply, deeply irritating that I have to be here to push pieces of paper, to run rules that I haven't taken the trouble to learn, and to give benefits that I in unaware of.

[Male, 22 years as GP, group practice (5), rural area]
Appendices
Appendix 1
Methods and Conduct of the Research

A brief description of the study design is given in Chapter 1. This appendix gives further details of the research methods used.

**Sample design and selection**

Because of the qualitative nature of the research, the sample of GPs needed to be purposively selected to ensure range on a number of key variables. A two-stage design was used involving first the selection of different areas and then the sample of GPs.

*The study areas*

Eight areas were selected in six geographical locations, each representing a different type of labour market in terms of levels of employment and the nature of occupations available. The areas were sited in five regions of England and in Wales and covered rural, suburban, urban and city locations. Unemployment levels ranged from 8% to 16%. In each area, a directory of GPs was obtained from the Family Health Services Authority (FHSA) from which the selection of GPs was made.

*The sample of GPs*

The key variables on which the sample of GPs was selected were as follows:

- Length of registration as a GP
- Gender
- Number of GPs in practice.

The selection also ensured that some of the practices were in health centres or medical centres.

On the three key variables, target numbers for interview were set as shown below (Table 8.1). The aim was to achieve maximum diversity in terms of the experience and practice types of the doctors.

**Table 8.1 Target sample of GPs**

<table>
<thead>
<tr>
<th>Size of practice</th>
<th>Gender of GP</th>
<th>Length of time in general practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single-handed 8-10</td>
<td>Male 28-30</td>
<td>Under 10 years 12-14</td>
</tr>
<tr>
<td>2-3 GPs 12-14</td>
<td>Female 10-12</td>
<td>10-19 years 12-14</td>
</tr>
<tr>
<td>4+ GPs 18-20</td>
<td></td>
<td>20 years or more 13-15</td>
</tr>
</tbody>
</table>

*Selection of the sample*

A sample of 86 GPs was selected from the FHSA records to provide approximately twice the number required in each of the above categories. All the GPs were sent a letter, signed by the DSS’s Principal Medical Officer, inviting participation in the study (see Appendix 2). The GPs were asked to notify the Department if they did not wish to take part and five withdrew at this stage. From the 81 remaining, the target sample was identified and approached for interview by SCPR. Fifty-three GPs were contacted at this stage, of whom 40 took part in a full in-depth interview. A summary of the reasons for non-response is given in Table 8.2.
Table 8.2 Response to the approach for interview

<table>
<thead>
<tr>
<th>Refusal:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- at time of initial letter</td>
<td>5</td>
</tr>
<tr>
<td>- at approach for interview</td>
<td>2</td>
</tr>
<tr>
<td>No longer in general practice/on maternity leave</td>
<td>5</td>
</tr>
<tr>
<td>No longer in practice in the area</td>
<td>2</td>
</tr>
<tr>
<td>Unable to take part during fieldwork period</td>
<td>4</td>
</tr>
<tr>
<td>Interviewed</td>
<td>40</td>
</tr>
<tr>
<td>Not contacted for interview*</td>
<td>28</td>
</tr>
</tbody>
</table>

* GPs who were not subsequently approached for interview were sent a second letter by the Department explaining that their involvement would not after all be required.

The response from GPs to taking part in the study was very positive, as reflected in the low refusal figures shown above. This was felt to be a consequence of the method of approach used and the importance that GPs attached to the study.

The composition of the sample interviewed is shown in Chapter 1. Because of the high level of response, it meets almost exactly the target requirements that were set.

The interviews

Once agreement to take part in an interview had been given, a letter was sent by SCPR to GPs. This gave further details about the coverage of the interview, confirmed the interview appointment, and asked for some information to be prepared in advance if possible (see Appendix 2). An appointment of approximately one hour was arranged for the interview.

The interviews were carried out using exploratory and interactive interviewing methods, based on a Topic Guide (see Appendix 2). Although each topic was covered with every GP, any follow up questioning was responsive to what was said by the doctor concerned. The interviews were tape-recorded so that full attention could be given to lines of questioning and so that all responses were fully captured.

The interviews ranged in length from 40 minutes to over 1½ hours, although the average was around one hour. The GPs were given a gratuity of £50 for the time they gave to take part.

Analysis

The tape-recorded interviews were transcribed verbatim for analysis. A systematic content analysis was then undertaken using Framework, a qualitative analytic method developed at SCPR.¹ The verbatim material was first indexed within broad categories and then charted within a thematic matrix. The charts contained a synthesis of the verbatim text, cross-referenced to locations in the transcripts as necessary. Four subject charts were prepared covering the following main topics:

- profile of IVB patients and conditions
- factors affecting the issue of statements for IVB
- the Reference Service and movement off IVB
- judgements, dilemmas and changes needed.

From these, interpretation of the material was carried out and the report prepared.

¹ A full description of the method appears in Bryn-tan and Burgess (eds). Analyzing Qualitative Data, (Routledge, 1993) (forthcoming)
Appendix 2 Fieldwork Documents

This appendix contains copies of the following documents:

- Initial letter sent by DSS to GPs
- Letter sent by SCPR to GPs
- Topic Guide used for interviews
13 October 1992

Dear Dr

I am writing to ask for your help with a study of Social Security incapacity benefits - in particular invalidity benefit - which is currently being undertaken by this Department, with the support of the Department of Health. We are carrying out a series of studies to learn more about the incidence and duration of benefit claims and the factors which cause people to move in and out of benefit. As part of this programme, the Department has asked Social and Community Planning Research (SCPR), an independent research institute, to carry out some research amongst general practitioners.

The study is small in scale and is taking place in six areas of the country. One of these is the area in which your practice is situated. The sample for the research has been carefully selected (from Family Health Service Authority records) to represent different types of practices, in terms of size and location, and to include GPs with different levels of seniority. We would therefore be most grateful if you would agree to be interviewed as part of the study.

If you are willing to do this, a researcher from SCPR will come to talk to you at your practice. The interview will take approximately an hour and SCPR will be paying an honorarium of £50 in appreciation of the time you give. The interviews will be taking place from the end of October to the end of November and SCPR will arrange directly a convenient time to meet with you.

All the information you give will be treated in the strictest confidence by SCPR. The evidence collected will be presented in a form from which neither your practice, nor your patients, could be identified.

If you are willing to be interviewed, you need do nothing. The researchers will contact you at the appropriate time. If you would like to know more about the study, or have any concerns about taking part, please do not hesitate to contact me personally on the above number.

I do hope you will be able to help us with this important programme of work. If, however, you do not want to take part, please let me know by 30 October 1992 and you will not be troubled further.

Yours sincerely

Dr Mansel Aylward BSc. MD. FFPM.RCP
Principal Medical Officer
26 November 1992

Dear

DSS Study of Invalidity Benefit

Following our telephone conversation, I am writing to give you some further information about the research and to confirm the arrangements we have made for the interview.

As you will know from the letter from Dr Aylward, the purpose of this research is to understand more about the factors that govern the incidence and receipt of social security incapacity benefits, particularly invalidity benefit. We would therefore like to talk to you about the range of circumstances in which you issue medical statements for patients who are incapacitated from work and about any difficulties that you may need to resolve in doing so. It would also be helpful to hear about some recent cases in which you have issued statements for your patients to claim, or to continue to claim, invalidity benefit. The Department is concerned to learn more about the ways in which it might further assist GPs in the decisions they have to take when issuing statements and these are other matters we will want to discuss with you.

At the start of our discussion with you it would useful to have a picture of the approximate numbers of patients that you treat who have been incapacitated from work for six months or more and the types of illnesses or conditions they have. If it is possible to have this information available in advance, without going to too much trouble on your part, this would be most helpful.

We would like to stress again that all the information you give will be treated in the strictest confidence by SCPR. Similarly, none of the information requested from you will be in a form from which your patients could be identified.

We have arranged an appointment for .... and I will come to the your surgery as agreed. We expect the interview to take approximately one hour and I hope it will be possible for you to make that time available.

We are most grateful to you for agreeing to take part in this study and I look forward to meeting you.

Yours sincerely

Jane Ritchie
Kit Ward
Wendy Duldig
Researchers
GPs and Invalidity Benefit
Topic Guide for Interviews
I. Background: GP and practice

- Type of practice/number of GPs/whether H/C or MIC
- Number of patients in practice
- Number of patients on GP's list
- Characteristics of practice catchment area
  - socio-economic
  - employment/level of unemployment
- Practice arrangements for seeing patients/extent to which continuity with individual patients
- Whether fund-holding practice
- Number of years as GP
- Number of years in present practice
- Whether FT/PT

2. Profile of patients on IVB

Clarify the IVB reference group i.e. patients with long-term sickness or disability for whom statements of incapacity for work have been issued for continuous period of 6 months or more

- Proportion/number of patients on IVB
  - below state retirement age
  - above state retirement age

- Whether any noticeable changes in numbers on IVB
  - over last few years (4/5)
  - any particular groups
  - views on reasons for any changes observed

- Nature of dominant conditions among IVB patients (obtain detail of conditions most commonly recorded on statements)
  - specific conditions underlying general diagnoses;
  - whether record specific or generic
    - reasons for using generic label (e.g. musculo-skeletal, rheumatism, bronchial, heart conditions)
  - whether any changes observed in dominant conditions over last 3-5 years
  - views on reasons for changes observed

- Length of statement period for IVB usually issued; reasons for differences

- Proportion (approximate) - or groups - of IVB patients for whom expects to continue issuing statements
  - for limited period (up to 1 or 2 years)
    - indefinitely
  - what distinguishes them

3. Awareness/understanding of statement conditions

- Awareness of change from sickness benefit (SSP or SB) to IVB for individual patients
  - how knowledge of change acquired
  - whether patients aware of change over

- Change of condition from sickness benefit to IVB (explain if necessary)
  - how conscious of this when IVB starts
  - whether any difficulties arise because of change in condition

- Whether any additional discussions with patients
  - before IVB begins (i.e. while on SB or SSP)
  - as IVB statements begin
  - initiation/content of discussions
4. Factors influencing issue of statements for IVB

- When making decisions about whether a patient on IVB is incapable of work
  - what factors are taken into account
  - what are the dominant factors

- To what extent - and how - is the issue of a statement influenced by
  -- the patient's age
  -- in relation to prospects of getting work
  -- effects of/incapacity from natural ageing process
  -- the nature of the patient's usual occupation
  -- opportunities for occupational rehabilitation
  -- the local labour market and prospects of finding work
  -- the patients previous employment/unemployment history

(Explore any not spontaneously mentioned)

- How do they judge these factors: what sources of information are used

- Discussions within the practice about signing statements

- Awareness of relative benefit levels for IVB
  - extent to which discussed with patients
  - extent to which taken into account in issuing statements

5. GPs' views on the judgements required

- Are there dilemmas in making judgements about capacity for work
  -- what are they
  -- in which situations are dilemmas greatest
  -- how do these dilemmas get resolved
  -- how could they be helped with these dilemmas
  -- use of second opinions; from where

- How confident do they feel in judging incapacity for work
  -- has their ability/confidence changed over time/with experience
  -- what has brought about that change

- Views about responsibilities GPs hold

b. Factors affecting discontinuation of statements for IVB

- What are the most common circumstances in which statements for IVB stop

- In what kinds of cases does
  -- GP intervention bring statements to an end
  -- patient's initiative end period of certification
  -- which is more common experience

- To what extent is there discussion with patients about preparation for discontinuation of statements

- influence on discontinuation of IVB statements (if at all) of
  -- fund-holding arrangements
  -- citizens' charter

7. Role of Regional Medical Service

- Experiences of RMS in decisions about IVB claims

- Extent to which they have disagreed with the decisions given
  -- where RMS has confirmed patient's incapacity for work
  -- where RMS opinion is that patient is capable of work
  -- awareness of procedures available if unhappy with RMO decisions
  -- actions taken in these circumstances
• Awareness of implications of continued certification after RMO has judged capacity for employment
  - reasons for continued issue of statements
  - awareness of appeal procedure

• Methods used to have patients' cases reviewed by RMS
  - means of signalling through content of statement

• Extent to which GP refers patients to RMS using RM7
  -- circumstances in which this has happened/outcomes
  -- reasons why not more widely used

• Extent to which seek advice from RMO/DSS about statementing procedures for benefits

• Communications from RMS
  - extent to which received
  - views on content
  -- how quickly able to reply

8. Recommendations for changes in procedures and guidance for IVB

• Suggestions for making GP's role easier in decisions/issue of statements for IVB; changes to take some of the burden off GPs shoulders

• Views on content of statement: whether conditions of statement should change

• Ways in which RMS procedures might be changed to help GPs with decisions about patients
  - value of fuller reports from RMO

• Are they familiar with DSS Guide
  - do they refer to it; when
  - suggested improvements

• Additional advice/guidance needed
  - in what form
  - value of regional seminars
  - in service/postgraduate training
Appendix 3 Forms used by GPs

Copies of the following forms are shown:

Form Med3. Medical statement

Form RM2. Request for medical report on patient, receiving IVB (used until December 1992)

Form RM2(BO). New Version of request for medical report on patient receiving IVB (introduced in December 1992)

RM7. Form for GP referral of patient to Reference Service
FOR SOCIAL SECURITY AND STATUTORY SICK PAY PURPOSES ONLY

NOTES TO PATIENT ABOUT USING THIS FORM

You can use this form either:
1. For Statutory Sick Pay (SSP) purposes - fill in Part A overleaf. Also fill in Part B if the doctor has given you a date to resume work. Give or send the completed form to your employer.

2. For Social Security purposes -
To continue a claim for state benefit fill in Parts A and C of the form overleaf. Also fill in Part B if the doctor has given you a date to resume work. Sign and date the term and give or send it your Local Social Security Office QUICKLY to avoid losing benefit.

NOTE: To start your claim for State benefit you must use form SC1 if you are self-employed, unemployed or non-employed OR form SSP1 if you are an employee, For further details get leaflet NI16 (from Social Security Local Offices).

---

### Doctor's Statement

**SPECIMEN**

<table>
<thead>
<tr>
<th>Doctor's signature</th>
<th>Date of signing</th>
</tr>
</thead>
</table>

**NOTE TO DOCTOR**

if you cannot fill this in yourself ask someone to do so and sign it for you.

### A. TO BE COMPLETED IN ALL CASES - PLEASE USE BLOCK LETTERS

<table>
<thead>
<tr>
<th>Surname Mr/Mrs/Miss/Ms</th>
</tr>
</thead>
<tbody>
<tr>
<td>First names</td>
</tr>
<tr>
<td>Present address</td>
</tr>
<tr>
<td>Postcode</td>
</tr>
</tbody>
</table>

**Date of birth**

<table>
<thead>
<tr>
<th>Date</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>National Insurance Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Works or Clock Number or Department</th>
</tr>
</thead>
</table>

### B. If the doctor has given you a date to resume work

<table>
<thead>
<tr>
<th>Date you intend to start work (or seek) work for any employer or as a self-employed person</th>
</tr>
</thead>
</table>

**For night shift workers only**

<table>
<thead>
<tr>
<th>Shift will begin at Time am/pm</th>
<th>and end next day at Time am/pm</th>
</tr>
</thead>
</table>

### C. FOR STATE BENEFIT CLAIMANTS ONLY

<table>
<thead>
<tr>
<th>Full name and address of employer (if employed)</th>
</tr>
</thead>
</table>

**DECLARATION**

I understand that if I give incorrect or incomplete information action may be taken against me.

I declare that because of incapacity I have not worked since the date of my last claim.

I also declare that my circumstances and those of my dependants are and have been as last stated. (If there has been a change cross out this declaration and attach a signed and dated statement of new facts.)

I declare that the information I have given on this form is correct and complete.

lapreethatadoctoractingonbehalfoftheDepartmentofSocialSeiltymaygetintouch with my doctor so that they may give the Department of Social Security any information which is needed to deal with this claim and any request to look at the claim again.

Signature........................................................Date...........................................

If you have signed this form for someone else please tick here...
REFERENCE OF PATIENT TO REGIONAL MEDICAL SERVICE

In Confidence

A Particulars of person referred

<table>
<thead>
<tr>
<th>BLOCK CAPITALS PLEASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname.......................... Mr/Mrs/Miss/Ms.</td>
</tr>
<tr>
<td>Other names..........................</td>
</tr>
<tr>
<td>Address..........................</td>
</tr>
</tbody>
</table>

Occupation.......................... Date of birth..........................

B To the DIVISIONAL/REGIONAL MEDICAL OFFICER

(see reverse of form Med 6 for address)

Dear Sir

I am issuing form Med 3/5 to my patient named above but should value another opinion. Please also see overleaf.

I should be glad, therefore, if you would arrange for an examination and report.

Yours faithfully

Doctor's

Date............................ signature..................................................

Name..........................................................................................

(BLOCK CAPITALS)

Address.......................................................................................

Telephone No

Date of first form Med 3/5 in present spell of absence from work

Diagnosis of disorder as stated on Med 3/5

History, present condition and prognosis

Previous treatment

The patient *is/is not able to attend a medical examination centre

I *do/do not wish to be present at the examination

Initials................. Date..........  

*Delete as appropriate

Printed in the UK for HMSO 9/89 L7d8151164 C700 27081
IN CONFIDENCE

A. If a final Form Med 3 has been issued:
I issued a final Form Med 3 to this patient on:

Signature ................................................
Date ........................................................

B. If a final Form Med 3 has not been issued:

HISTORY and PRESENT CONDITION

FITNESS TO ATTEND at a Medical Examination Centre:
In my opinion the patient *IS ____ fit to attend.
IS NOT
*Please delete whichever is inapplicable and if unfit give reasons.

If you wish to be present at the examination of the patient please initial here .................................................. Date ..........................................................
To
Dr.

Dear Doctor

I understand that the above-named person is under your care and that you have issued Form Ivied 3/Med 5 or other medical evidence in support of a claim that this person is incapable of work. The local office handling the claim for benefit has asked for information regarding the patient's present state of health and for an opinion on capacity for work.

I should be grateful if you would give overleaf any information which you think would be of help to the medical officer dealing with the case, should it be found necessary, judging from your report, to arrange for an examination.

Examinations are usually carried out at the nearest examination centre or at the patient's home. If you wish to be present I shall arrange for a day and time to suit your convenience.

Will you please return this form with the sections completed as appropriate to reach me not later than the morning of ...............................................................

(If there are exceptional circumstances which make it impossible to return this form by the date stated, it should be returned, duly completed, to reach me not later than the morning of the second day after that date-excluding Sundays and Public Holidays).

If you are not treating this patient under the National Health Service Act as a general practitioner, you are under no obligation to provide this information but any assistance you can give me will be in the interest of your patient and will be much appreciated, although I regret that no fee will be payable for it.

Yours sincerely

Dr. C. J. BOLT

Divisional Medical Officer

NB-We will write to you again if the patient is examined, or is summoned but does not attend. However, in order to save costs, I am no longer writing where it is decided that examination is unnecessary. In such cases please accept my thanks for your report.

Form RIM (OVER)
Dear Doctor

REQUEST FOR MEDICAL REPORT

I am writing to you because the person named above is claiming a Social Security benefit and the Benefits Agency office dealing with your patient's claim has requested my opinion on the person's capacity for work.

I have your patient's written consent, on the application form for benefit, to my seeking a report from you. I would be grateful therefore if you could provide one by answering the questions overleaf and returning it in the enclosed reply-paid envelope within 10 days of the above date. A comprehensive report may enable me to reach an opinion without requesting your patient to undergo a medical examination.

May I draw your attention to your obligation under your Terms of Service to provide me with clinical information if you are providing medical services under the NHS Act and have issued a doctor's statement to your patient. If you are not treating the patient under the NHS or if you have not issued a doctor's statement you are not obliged to let me have any information. Nevertheless I would still appreciate any information you can give me as it may help your patient, although I am unable to pay you for providing it.

Should your patient's records be unavailable for any reason or should this person no longer be registered with you, I would be grateful for any information you can provide by completing as much of the questionnaire as possible. If you know with whom the person is now registered, please let me know the new doctor's name and address.

If I decide to invite your patient to attend for an examination, you will receive a further letter to let you know the opinion I have provided to the Benefits Agency. If your patient is not invited to attend, I shall not write to you again but I thank you in anticipation for a helpful report. I may need to seek further information at a later date if your patient continues to claim benefit.

Yours sincerely

DR PETER F LARMOUR

Senior Medical Officer
Has a final statement been issued?  
*Yes/No

If so, date of issue

If a final statement has not been issued could you please give me a report on the following matters:

1. Diagnosis

2. History, Treatment and Progress

3. Future Management

4. Ability to perform some form of work, either now or in the near future.

Is your patient fit to attend by public transport?  
*Yes/No

If no, please give reason

Do you wish to be present at the examination?  
*Yes/No

IN CERTAIN CIRCUMSTANCES, THIS REPORT WILL BE RELEASED TO YOUR PATIENT OR HIS LEGAL REPRESENTATIVE OR AN APPEAL TRIBUNAL

Signature...........................................................................Date...........................................

'Delete as appropriate

RM2(BO)(Reverse)  
S.705X  12/92