Family Practice Grand Rounds

Difficulties in Disability Assessment

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DR. JAMES B. EBERSOLE *(Professor, Department of Family Medicine, and Associate Director, Family Medicine Residency Program)*: Today's topic is disability evaluations in the office. Dr. Collin Baker, one of our panel members, has prepared three re-enactments of common situations to introduce several problems in this field, following which we will have a panel discussion of these and other problems. The first scene depicts an interview with a high school basketball coach and a family physician who is the team physician.

Scene 1

TEAM PHYSICIAN: Hello, Coach. How are you?

COACH: I am glad you stopped in. I wanted to talk about Tim Connolly's problem. What's all this about the cast?

TEAM PHYSICIAN: I knew you would be surprised about that. He has severely sprained his ankle.

COACH: The hospital said the x-ray examination showed no fracture.

TEAM PHYSICIAN: That's right, there is no fracture.

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COACH: But the cast! Six weeks, Doc, six weeks!

TEAM PHYSICIAN: We need to consider this sprain as if it were a fracture. The ligaments that connect the bones in his ankle have been torn completely.

COACH: He was limping around a bit, but you know, big games are coming up. We have Central coming up, and we have West. We lost to East by a point, and lost a couple of other close ones. We can't afford to lose his 15 points. Tim is our best player!

TEAM PHYSICIAN: I realize that, but he is not going to be worth anything to you with a bad ankle.

COACH: Couldn't you inject him with a little novocaine? The pros do it all the time. These are big games.

TEAM PHYSICIAN: That's fine for the pros, but this is a high school athlete. We just can't take chances with his ankle.

COACH: The team wants him to play, the parents want him to play . . . I mean, between you and me, Doc, my job is on the line. I need this season. We need this championship.

TEAM PHYSICIAN: You really need to consider this a serious injury. If he had fractured his ankle, would you have him playing?

COACH: No, but there are a lot of other doctors in town who have been injecting players on other teams; I have talked to the coaches.

DR. EBERSOLE: Now, we will move on to the next scene, which portrays a school teacher coming to see her family physician.

Scene 2

FAMILY PHYSICIAN: What can I do for you today, Ms. Barnett?

SCHOOL TEACHER: Well, Doctor, about two weeks ago I was out sick for three days with the flu. I didn't feel it was serious enough to come in here, and I hated to bother you, so I just called in and reported to my principal. When I went back, however, she said I would need a statement from you stating that I was sick, and I am here to get a certificate to that effect.

FAMILY PHYSICIAN: I can appreciate your feeling that your illness was not serious enough to come in, but I would find it hard to write a note saying that I knew you were sick. I believe that you were sick, but it is difficult for me to write a note without having had any contact with you.

SCHOOL TEACHER: Doctor, I've been seeing you for about five years and I was in four months ago. I am sick very seldom, and you know I do not tell stories.

FAMILY PHYSICIAN: Oh, I believe that; however, I do not feel that it is ethical for me to write an excuse for something that I never even saw you for.

SCHOOL TEACHER: Well, I guess that is the way it has to be then. If you cannot do it for me, I will have to talk to my principal again.

DR. EBERSOLE: I am sure most of us have felt the same ambivalence and discomfort the physician exhibited in dealing with this particular kind of patient. For the last scene we decided to portray a typical patient from the residency practice. This patient is obese, hypertensive, and diabetic and is well known to us as having many chronic problems.

Scene 3

FAMILY PHYSICIAN: Good morning. I have not seen you for quite some time.

PATIENT: Good morning. Yes, it has been a long time . . . six months or more. I am behind in my treatments and tired and run down. I feel terrible. I am sick and frustrated and depressed.

FAMILY PHYSICIAN: How have you been feeling since we saw you six months ago?

PATIENT: I have been feeling poorly. My medicine ran out, and I haven't had the money to buy more. I am way behind and I am very ill because of it.

FAMILY PHYSICIAN: I notice your blood pressure today was 160 over 100. Have you run out of your blood pressure medicine?

PATIENT: Yes, I ran out of it, and I gained too much weight, and I need to lose weight. If I try to walk, I get too tired. I do not get the proper rest, and I seem to be yawning and sleeping all the time.

FAMILY PHYSICIAN: As I recall, you were laid off by the textile plant a little over a year ago. Is that right?

PATIENT: Yes, sir.

FAMILY PHYSICIAN: Are you still getting unemployment insurance, or has that run out now?

PATIENT: That has run out.

FAMILY PHYSICIAN: Do you get any kind of alimony from your divorce?

PATIENT: No alimony at all.

FAMILY PHYSICIAN: How are you managing financially?

PATIENT: I am just barely getting by. I came today to see if you could get me on Medicaid disability so I could get a little more money.

FAMILY PHYSICIAN: Have you been making an effort to find a new job? I mean, have you actually been going around looking for openings?

PATIENT: No, sir, I haven't. Lately, everywhere I went I was rejected, so I got discouraged and a little testy about it, and I decided to leave it alone for a while.

FAMILY PHYSICIAN: I think it is very unfortunate that you have these chronic medical problems. They do create a real burden for you, but on the other hand, you are fortunate that all these problems can be improved if we could work together a little more regularly and conscientiously. It would not be fair to say that you are permanently and totally disabled at the moment.

PATIENT: But, Doctor . . .

Discussion

DR. EBERSOLE: At this time I want to introduce our panel. Dr. Collin Baker is the Director of Undergraduate Programs in the Department of Family Medicine. Dr. Greg Tuttle is a third year family practice resident. Dr. Lawrence Jowers is a family physician in private practice in Columbia; Dr. Jowers also has a degree in law. Dr. David Adams is a clinical psychologist. Dr. Simons Hane will moderate the discussion.

DR. SIMONS HANE *(Third year family practice resident)*: Dr. Neff, do you have any response to any of the program?

DR. GEORGE NEFF *(Director, Spartanburg Family Medicine Residency)*: You certainly have done a good job of selecting cases. We all can easily identify with each of these scenes.

DR. ANDREW WHITE *(Third year family practice resident)*: One of the things that struck me was how ambivalent the interviewers were, particularly in the second and third cases. They kept saying "it would be hard," or "difficult," or "tough for me to do that," rather than coming right out and saying, "I just can't do it." The physician in the third case made the statement, "it would not be fair." I, too, feel the same ambivalence when I am dealing with similar patients.

Another comment that struck me was the coach's implication: If you will not get this patient fixed up right, there are many other physicians in town who would be prepared to do it. And the last two patients easily could have gone to another physician who would have been happy to write some form of excuse for them. That is a point I would like the panel to address.

DR. HANE: Thank you. Dr. Jowers, would you like to respond?

DR. LAWRENCE JOWERS *(Family physician)*: The conflict presented in the basketball scene is a common situation, occurring especially when there has already been some controversy about similar decisions the team physician made that did not suit the coach. One must remember, however, that a second opinion will not change the nature of the injury. The major function of the team physician is to decide whether this man can play regardless of the medical treatment that someone else might use. His responsibility is to the injured player.

DR. COLLIN BAKER *(Director, Undergraduate Program, Department of Family Medicine)*: But just as coaches are expendable, so are team physicians. His job may be on the line too.

DR. JOWERS: Having been a team physician, and having known a few of them in high school, the reduction in income would not be much.

DR. GREG TUTTLE *(Third year family practice resident)*: There are multiple pressures this team physician must be feeling, not only from the coach, but also probably from family members of the young athlete. His mother and his father certainly have a lot of influence; they may be putting a great deal of pressure on the coach, and indirectly, on the team physician.

DR. BAKER: Certainly, the relationship between the physician and the patient and his family is tremendously important, and we are assuming that this relationship has been built up over a period of time. If so, the physician may need to explain directly to the parents the need for six weeks of disability.

DR. PAUL BEUHRENS *(Third year family practice resident)*: Each of the three scenes demonstrates difficulties in the physician-patient relationship that frequently occur in disability cases. It is an area where forming an alliance with a patient is sometimes extremely difficult.

DR. DAVID ADAMS *(Clinical psychologist)*: The physician in this particular instance took a great deal of time educating the coach about the nature of the injury. The thing he did not do was educate the coach about his own role as a team physician and the role of other physicians in consultation. I think he could have explained his position to the coach.

In the second case, it is interesting to note that the physician had educated his schoolteacher patient to properly utilize the health care delivery system; that is, she should not come in when she had a self-limiting disease. Yet he had no options available when the patient actually followed his instructions. This left the patient with no way to verify to others the disease she herself had treated. However, the physician did have the option of certifying the length of his relationship and his past experience with the patient without certifying this particular illness. In most cases that might be sufficient for the employer.

DR. TUTTLE: Regarding that case, it would have been easy to go ahead and give this patient an excuse. In some ways that would solve the problems of all concerned. This patient had been considerate of the physician and had not bothered him with what she understood to be a self-limiting illness. She was asking him to be considerate of her.

DR. JOWERS: When a certificate for absence from work is needed, a great deal more is involved than simply a relationship with the patient because that person will probably be drawing money for those days he or she was not working. The physician must be very careful. If you certify the patient as being ill when in fact she was not or when you are not certain that she was ill, you may be perpetuating a fraud. Malpractice insurance does not cover this; fraud is a crime. There are ways in which to handle similar situations with patients you know well, but the pitfalls must be considered.

DR. BAKER: One ploy that might be used is to write a note saying this patient *states* she was ill with the flu for three days at a certain time. Often all the employer wants is something in the file.

DR. BEUHRENS: One issue that has not been discussed is exactly who does determine whether the disability claim is valid. It seems to me that is not an issue the physician alone can decide. I agree that a physician should not verify what he has not seen. He should verify only what he knows about the patient and what she states is fact. I also agree with Dr. Baker about simply stating that the patient states she had such an illness. The physician can state either what he knows about the patient and the illness or what the patient has told him. The employer must decide whether such certification justifies sick pay. I do not think there is any need for the physician to determine whether the patient was disabled.

DR. JOWERS: I want to comment on the third case, the woman whose claim of disability was rejected, offhand, by the physician. It is easy to prejudge a patient after the interview and before the examination. We prejudge because of our own knowledge of what other people can do with similar problems and because of such factors as noncompliance and negligence. When patients present with problems that involve disability, the physician must be completely objective. Only through total objectivity can a physician record the facts others need to evaluate for the determination of disability.

DR. NEFF: I want to second these comments about the role of the physician in disability determination. Physicians do a poor job of educating the patients about who makes disability determinations. I make a particular point of telling my patient who says, "Why did you take my disability away?" or "Can you give me disability?" that it is not the physician who makes that decision. We make a report of the facts only. This lets patients know what the physician's function is. Physicians do not ultimately determine disability. One thing that does bother me is the last question usually found on the forms, "Is this patient disabled?" Do you have any comments about that?

DR. BAKER: That question is on some forms; for example, the Department of Social Services Medicaid form and some insurance forms ask, "Is this patient totally disabled or partially disabled?" and "When can the patient return to work?" The physician has to make some judgment about that; however, I think Dr. Neff is correct in saying that the physician does not determine the disability. He may give his opinion about disability. A reviewing board determines the disability.

DR. TUTTLE: Yes, but we must remember that we are patient advocates as well as physicians, and after objectively assessing the patient's degree of impairment, it is up to us to go to bat for the patient if it is appropriate.

DR. BAKER: You are quite right, and that's important. Sometimes you will send in an evaluation on a patient whom you feel sure is disabled under the rules of the department, and the patient will be turned down. Sometimes the decision is purely perfunctory. I think it is up to the physician to go to bat for the patient, go to hearings to testify, if necessary, in order to follow up.

DR. JOWERS: Along that same line, it is pertinent for us to remember that disability is not a fixed status. Disability is defined differently by different government agencies. A person can be totally and permanently disabled as far as his/her own personal life insurance or salary insurance policy is concerned and be in no way disabled according to Social Security guidelines.[1,2]

DR. NEFF: In determining the disability of the third patient, the lack of compliance by the patient does not make her disabled. If she is disabled because of an endogenous depression, that may be legitimate.

DR. JOWERS: We have not discussed whether this woman might be disabled simply because of her emotional or psychological impairment. She presents with a degree of depression, using the terms "discouraged" and "frustrated;" perhaps this, in addition to the fact that she is a hypertensive diabetic, keeps her from seeking employment.

DR. ADAMS: The Office of Hearings and Appeals of the Social Security Administration has an M-5 form, which applies to psychological disability. Basically what the Office of Hearings and Appeals wants to know is whether the individual is showing signs of organic brain syndrome, a personality disorder, gross psychosis, anxiety disorder, or related disorders. Any intellectual deficit that would impair the individual can be the basis for a claim of disability. There is a check sheet, the Residual Functional Capacity Inventory, to which Social Security wants you to respond, asking, "Is this individual's capacity sufficiently impaired that he/she cannot function in social and work related situations?" So there are some objective measures of emotional disability.

DR. HANE: Are there any more comments?

DR. BEUHRENS: It seemed to me that once disability was mentioned, especially in the last two scenes, it tended to dominate the whole interaction between the physician and the patient. Perhaps we sometimes forget our role as healer in providing health care. For example, the physician in the third scene seemed much more interested in gathering facts regarding the disability determination than in applying himself to the patient's other problems.

DR. BAKER: I was wondering if this sort of problem arises when care of the patient is compartmentalized, that is, according to medical care, psychosocial care, determination of disability, and so on. A good physician must cover all of these fields in dealing with patients, and he must represent the interest of the patient in health matters and psychosocial matters as well as disability matters.[3,4]

DR. HANE: In summary, while situations requiring the physicians to make statements about the disability of patients are common in family practice, the physician has no special expertise in determination of degree of disability. The cases presented today demonstrate some of the problems that may arise and emphasize the need for careful evaluation of the patient's problems and caution in making statements about the disability caused by the problems. These cases have also pointed out the importance of interpersonal relationships in managing problems of this kind.

References

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