Family Practice Forum

Disability Assessment and the Family Physician

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The ultimate adjudication of disability usually rests with a nonphysician, but its accuracy depends on the validity of medical evidence supplied by physicians. Few family physicians make it through a week without seeing a patient whose chief complaint is "disability forms," yet most find their involvement frustrating and tedious, and respond less effectively to this administrative duty than to more clinical challenges. The heavy impact of this disenchantment falls on patients, insurers, employers, taxpayers, and very much on the credibility of our specialty, for family physicians, above all other physicians, should be willing and well able to provide the required input.

Consider, for example, that a delay in submitting a report can cause the decision-maker or the patient's attorney to initiate a new round of consultations, putting the patient through unnecessary examinations and tests, some of which might involve risk. And a late report might receive less attention than it deserves, simply because other reports will be available, a counterproductive result: how many family physicians bemoan the "fact" that agencies give too much weight to the opinion of a high-powered specialist who has done a five-minute, one-shot assessment? For the patient, physician delay translates into delayed adjudication, a hardship for those meeting a program's requirements and perhaps a deterrent to prompt return to work for those who do not. More important to the physician-patient relationship is the patient's predictable anger, fueled by an agency's notice that "your physician has not yet submitted the required reports." An incomplete report generates another set of problems, and frequently, further delay. For example, failure to describe the "extent of the impairment" with something more than a label, such as "moderate," can lead to further requests for information.

But a response that is not objective has a far more devastating effect than a late or incomplete report. Bias can creep into a report in two ways: the physician's documentation of data can be inaccurate or misleading, or the opinions regarding the extent of the impairment and the existence of disability might not follow logically from the data base. To be sure, the former is more harmful than the latter, since the person evaluating the report is likely to discount an opinion clearly at odds with the facts but usually has little choice about accepting the data base itself. Either way, overstating an impairment might well contribute another free rider to the system, and one can only speculate on the detriment to the patient of being adjudicated disabled and having then to live the role. Similarly, an understatement can lead to denial of benefits to which the patient has earned the right. These benefits might be all that will keep this patient and his family above water. Moreover, whether a pa-

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tient is indigent or independently wealthy, he has the right to objectivity.

Why do physicians have such trouble with disability assessments? First, few understand their role, yet knowledge of what each program requires and expects from physicians is fundamental to effective participation. This is not surprising. "Disabled," after all, is a technical term applied to a patient who has met all of a specific program's requirements to prove disability. Thus, there are many definitions of disability, each relevant only to the program that generated it, accounting for the sometimes exasperating result that a patient considered disabled by one program, such as Workers' Compensation, might be denied benefits by another, such as the Social Security Disability Insurance program. The root of the problem lies in the tendency of physicians to equate impairment with disability; in fact, the disabled always have an impairment, but the impaired are not always disabled.

Confusion about the technical requirements of their role, then, leads to frustration and suboptimal input, but the real reason physicians find disability assessment and reporting a chore may well be that they divorce it from clinical medicine. Yet it is one of the few situations requiring an assessment of function relative to specific demands: work requirements, activities of daily living, or something in between. It is an opportunity to review the patient's entire history and to verify the accuracy and completeness of the diagnosis and the appropriateness of therapy. And it is a chance to get to know the patient and his problems better.

Assessing a patient's impairment for "disability" purposes is far more than doing a history and physical examination, just as reporting data and submitting opinions about that impairment requires more than a passive filling in of blanks on a form. Ironically, few family physicians are trained to handle this important function. It is time to make competence in disability assessment a specific educational objective in family practice training programs and continuing medical education seminars for practicing physicians, and it is time to include the subject in recertification examinations.