ACCESS TO BENEFITS

Results of an Advice Services Alliance consultation exercise on the standard of medical examinations conducted in connection with social security benefit entitlement in Northern Ireland.

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1. Introduction

Advice Services Alliance (ASA) is the umbrella body which represents the interests of the independent voluntary advice-giving organisations in Northern Ireland. The Alliance comprises the Association of Independent Advice Centres (AIAC), Law Centre (NI) and the Northern Ireland Association of Citizens Advice Bureaux (NIACAB).

Part of the ASA’s remit is to meet with the Social Security Agency on a quarterly basis to raise issues of concern on behalf of the advice sector.

Several members expressed their concern at the behaviour of some Medical Officers from Medical Support Services. In order to qualify for most disability or incapacity related benefits, it is common for claimants to be examined by Medical Officers from Medical Support Service (MSS).

Reports are frequently request by DLA branch to measure the extent of a claimant’s disability and how this affects normal daily living. Claimants are usually visited at their home by Departmental Examining Medical Practitioners to obtain this information.

Incapacity Benefit claimants are regularly subject to examinations by Departmental Medical Officers to assess incapacity for work. The test for incapacity is known as the Personal Capability Assessment (previously known as the All Works Test). This assesses a persons ability to carry out functions both physically and mentally.

Medical Support Services are part of, and are responsible to, the Social Security Agency (SSA).

As a result of this, a short monitoring exercise was conducted to measure the extent of the problem. Responses were received from 22 advice centres across Northern Ireland and the cases highlighted by the agencies form the basis of this report.
2. Summary of Evidence

The following is a summary of the evidence received from the consultation exercise carried out within the advice sector in Northern Ireland. The findings are reproduced in full in section 3.

2.1 Delays

It is reported that delays can occur between the client’s application for benefit and the medical examination. This can cause problems as some Medical Officers (MOs) do not routinely ask about deterioration of the client’s condition, particularly in relation to Incapacity Benefit where MOs tend to focus on the information contained in the initial claim form (IB50). This is not the case with Disability Living Allowance as Examining Medical Practitioners (EMPs) usually get more up-to-date evidence from clients when conducting examinations.

Some advisers are concerned that in certain rural areas, examinations for benefits (particularly in relation to DLA) are ‘grouped’ which tends to delay the process for some clients, as examinations do not take place until there are sufficient numbers.

2.2 EMP’s failure to keep appointments

There needs to be a more robust system in place that will allow the client to be informed when an EMP is not able to carry out the examination on an agreed date.

2.3 Problems with legibility of medical reports

Advisers and clients have difficulties understanding reports due to the illegibility of some reports. This can cause problems for appeal tribunals also.
2.4 Length of time allocated for examinations

This is an issue particularly in relation to Incapacity Benefit examinations. However, it was also felt that some examinations for DLA were rushed. This issue is often raised at appeal hearings. MOs and EMPs should be allocating more time to explore instances where there are both physical and mental health problems.

2.5 Incapacity Benefit reports

The issue of ‘sameness’ of reports has been observed, with advisers indicating that this occurs both for the same doctor with different clients, and also between doctors. There is a tendency for the ‘typical day’ section of the Incapacity Benefit medical report (IB85) to be disputed. These include:

- Reports written to a set system (often hotly disputed at an appeal hearing as inaccurate);
- inaccurate interpretation of descriptors;
- inference that because clients can climb onto a couch they can then climb a flight of stairs;
- inappropriate observations such as ‘client well groomed’, ‘client sat comfortably for 30 minutes’ while the examination only lasted a total of 30 minutes.

There appears to be scepticism over certain medical conditions, such as Myalgia Encephalomyelitis and Chronic Fatigue Syndrome despite the fact that the Incapacity Handbook for Approved Doctors contains helpful guidance for such cases.

2.6 Inconsistency

Advisers indicate inconsistencies between MOs (Incapacity Benefit reports) and EMPs (Disability Living Allowance reports). Where these two examinations take place within a short time of each other, it is not uncommon for the findings to be notably dissimilar.
An issue of continuing concern among advisers is the practice whereby medical reports are passed from Incapacity Benefit to Disability Living Allowance when a client fails the Personal Capability Assessment (PCA). This triggers a re-examination of the current DLA award. There is no such transfer of information when a client passes the PCA and is not receiving DLA.

2.7 Doctors Attitudes
Some advisers have provided client evidence of doctors being brusque, unsympathetic, disbelieving, sceptical, rude and hurried.

2.8 Monitoring of Doctors
It is our understanding that MSS monitor 1% of cases internally. This is a paper-based check with no third party involvement. This needs to be re-examined and a more robust scheme introduced.

SSA should monitor cases where appeal tribunals reject the findings of Medical Officers/Decision Makers and substantially increase the number of points in the PCA. This clearly highlights shortcomings in the examination process.

Consideration should be given to the Social Security Select Committee Report on the Benefits Agency Medical Service (20 April 2000)
http://www.publications.parliament.uk/pa/cm199900/cmselect/cmsocsec/183/18302.htm

2.9 Information
Adequate and appropriate information should be made available to clients regarding the medical examination process. For example an advice centre has developed two leaflets designed to inform clients about the medical examination process for both Incapacity Benefit and Disability Living Allowance/Attendance Allowance. These leaflets are significantly more detailed and tailored to clients information needs than any information
currently available from MSS.

2.10 Training

This should be an ongoing priority in terms of:

1. dealing with clients;
2. disability awareness.

Continuous training should be available on MSS Profession Standards as set out in Appendix 1.

2.11 Complaints

This section links to the information section. As a matter of course clients should be given a ‘How to complain’ leaflet at any examination attended. This will empower clients, ensure that good practice is maintained on the part of doctors and will allow MSS/SSA to monitor the quality of service provided.

2.12 Procedures

When carrying out examinations, Medical Officers have access to previous medical reports carried out for the purposes of entitlement to other benefits. This is likely to reduce the ‘independence’ of medical reports, as reports in these circumstances tend to be similar to and supportive of previous reports.
3. **Detailed Evaluation of Evidence**

The following is a reproduction of evidence obtained from the consultation exercise. The examples have been categorised under the most appropriate issue.

### Delays

An adviser was also aware of cases where the claimant remained at home all day waiting for the doctor who never arrived and no explanation was ever given.

In one particular case the adviser rang DLA Medical Branch and asked why a claimant had to wait an unacceptably long time for the visit from the doctor. The adviser was told that this was due to the geographical location and unrest in the Tyrone area. The adviser then explained that Dungannon is at the end of the M1 Motorway and there was no more unrest in Dungannon than in any other part of the province.

A **Bangor** client with multiple mental, physical and alcohol problems and poor literacy skills was in receipt of SDA and required a medical examination in order to stay on benefit.

The benefit was suspended prior to sending out an IB50 or the setting up of a medical examination. The client managed to read the part about the benefit ending, not the small print or the response slip at the end. If she consents to an examination, they will continue with the payments, on the understanding that if she fails the medical, the money will have to be repaid. The advice centre contacted IS in an attempt to provide the client with sufficient monies until the case was sorted out, but IS have a problem as without SDA, she doesn’t have the qualifying benefit to get IS. In effect, the client’s payments have been suspended with no evidence and the client is still waiting for Medical Support Services to arrange an examination. There was no alternative but to accept the interim payments, leaving the client open to an overpayment situation should she fail the
medical, - this was through no fault of her own.

An Armagh client, age 54, living between Portadown and Armagh was asked by Royston House to attend an Incapacity Benefit medical examination in Belfast. The Advice Centre telephoned Royston House on behalf of the client and was told this was because of a backlog of cases in the Portadown area. When questioned if this was legal the reply given that they were not sure of the legality of it. The adviser was then put on hold and after a time was informed the appointment would be cancelled and relisted for Armagh or Portadown.

A Newry client applied for DLA and included doctor’s evidence some months previous but the client is still waiting on a decision despite repeated calls. DLA branch stated the reason for the delay is that no doctors are available to carry out the visit.

EMP’s failure to keep appointments

A Bangor client had 3 EMP visits arranged and on each occasion the EMP did not present. The client was told that the EMP went to the wrong address. The Advice Centre called DLA to check that they had the correct address for the next visit, but they still had the wrong details on computer.

Problems with legibility of medical reports

As a result of three separate awards a Derry client had been in receipt of DLA for 5 years. This was disallowed from and including 19/02/01, i.e. the day after his 9th birthday. For the period 19/2/99 to 18/2/01 the child had been in receipt of middle rate care component by reason of dyspraxia, poor vision in left eye, asthma, eczema and speech/language problems. An EMP had visited on 13/01 and a decision to disallow benefit was made on 12/3/01. A copy of a medical report by a senior educational
psychologist was forwarded to DLA branch on 21/3/01 together with a request for revision.

According to the EMP the visit took place from 3.55pm to 4.35pm, the child’s mother strongly disputed this saying the EMP left at 4.15pm after asking directions to his next visit and that he kept looking at his watch throughout the visit, indicating that he was running late. At 4.10pm the EMP closed his briefcase and went to leave without seeing the child. The EMP reluctantly agreed to see the child for 5 minutes at the insistence of the child’s mother. The EMP report is virtually illegible and obviously written in a great hurry. Difficult to know what has been written although EMP concludes that the child is a normal 9-year-old with no real care needs. The report written by the Senior Educational Psychologist takes a completely different view and would support what the child’s mother has been saying on page 24 of the DLA Self Assessment Claim Pack. The consultant paediatrician basically said that the child suffered from a number of significant conditions affecting his daily life and his ability to live independently. The dyspraxia was described as severe and the consultant concluded that the child required constant supervision and attention of a level above that of an average child his age. DLA branch has been informed of the child’s mothers’ outrage at the EMP report and the manner in which the visit was conducted.

The above issues concerning the length of EMP visits and illegibility of medical reports arise quite frequently.

Length of time allocated for examinations

An Omagh client was found capable of work in a decision dated 28/06/00. She suffers from physical problems including back pain, vertigo causing dizzy spells and impaired hearing. In addition to this she also had mental health problems which affected her ability to cope with daily living. At an assessment lasting 15 minutes, the doctor
concluded she had no significant physical limitations and scored her 4 points for mental health.

After studying the case papers, the adviser’s greatest concern was the short time it took to conduct the assessment – the adviser felt it would be liable to contain an inaccurate reflection of the client’s problems. Having studied the medical report it became apparent that it was less than accurate.

The observations included “the client sat comfortably for a long period”. Given that the assessment was only 15 minutes in duration the adviser found this observation misleading particularly as the client had recorded in the IB50 that “she could not sit longer than 1 hour”. No points were awarded for activity 17(a) which is the descriptor that asks whether stress was a factor in the client giving up work. The medical examiner had recorded, “gave up due to pregnancy”. The client gave up work and had been in receipt of Incapacity Benefit from 5/2/96 due to stress. Her first child was born in January 2000. The above inconsistencies were evident throughout the IB85 report. The medical examiner had recorded in numerous places that our client seemed OK. At the tribunal the adviser raised the inconsistent nature of the findings and also the issue of the inadequate time period allowed for an examination of someone with both physical and mental health problems.

A Newtownards client was called for examination at Royston House on 22/11/00 in connection with Incapacity Benefit. The MO would not let the client explain his condition or how it affects him on a daily basis. She kept interrupting him and did not record anything he told her. The client felt that the details in the medical report were based on her personal opinion and were not factual. Also the report notes that the examination lasted 40 minutes. The client said he was in and out of the examination within half an hour.
A Bangor client attended a medical examination at Royston House. The client was examined by a doctor who he states was “Unkempt and smelt of alcohol.” The examination lasted 8 minutes, yet the client has been told that the doctor recorded that the examination lasted 58 minutes. The client has stated that a friend of his had a similar experience with the same doctor six months previous.

An Newtownards client suffering from neurosis and chronic anxiety attended for a medical examination for ICB. She informed the advice centre that every time she tried to explain her condition to the medical officer, he put his hand up stating that he had all the necessary information in front of him. When the client received a copy of the medical report, she noticed that she had not been asked any of the questions on the mental health part of the form. The examination took no longer than 15 minutes. The handwriting on the report was very poor and it was hard to read.

An East Belfast client received papers for a DLA appeal. During discussion the client said that the EMP stated that she is left-handed. The client is actually right-handed. The EMP asked the client to sign the form stating that the examination lasted 45 minutes when in fact it only lasted 10-15 minutes. The client feels strongly that the EMP did not accurately state the facts.

Incapacity benefit reports

An Omagh client had been unfit for work since 28.02.90. Since the introduction of the All Work Test he had been subject to several medical examinations to test his incapacity, all of which he had successfully passed. On 28/07/99 he was again examined under the All Work Test. He scored 9 points and as a result was found capable of work.

Prior to the client’s appeal the adviser conducted an in-depth interview with the client, which involved close examination of the casepapers. The client informed the adviser that
the doctor who examined him had previously examined him approximately one year earlier. When the client presented for examination on 28/7/99 the examining doctor recognised him and asked if things changed since last year. The client told the doctor that his problems were the same and the examining doctor then told him that as things had not changed he would not detain him for long. The client left the examination feeling that as he had previously passed the All Work Test that this was likely to be the case again.

During examination of the IB85 the Doctor had recorded that the client “walked his dog for half an hour every spare day” and “client was able to dress unaided and lace up his shoes”. The adviser put these observations to the client and the client said he did not have a dog and that due to his physical problems he had been wearing slip on shoes for many years.

At the tribunal the adviser raised concern about the inaccurate observations and also about how the doctor had reacted when he recognised the client. The tribunal requested from the Departmental representative a copy of the previous IB85. In submitting this to the tribunal the Department representative conceded that it was very similar in content to the current IB85, therefore it was a possibility that the information could have simply been transferred from one IB85 to the other. The appeal was subsequently allowed and the client was awarded a total of 17 points.

**Inconsistency**

An **Omagh** client was medically examined on 8/12/99 and in a decision dated 28/02/00 was found capable of work with a score of 11 points. The client subsequently appealed against the decision.
Following discussions with the client it transpired that an EMP had examined him for the purposes of DLA on 9/12/99, which was the day after his examination under the All Work Test. He was awarded DLA mobility at the higher rate and care at the middle rate. A copy of the EMP report was requested. The report was in sharp contrast to the IB report. The EMP report confirmed that the client’s mobility was reduced to 50 yards and that he had substantial impairment to both knees, left shoulder and slight impairment to his left hand and wrist. The EMP also recorded that the client had severe prolonged headaches, which rendered him totally incapacitated. In contrast, the examining doctor found client to have no problems walking or using stairs, no problem with sitting, bending/kneeling or lifting/carrying. Most noticeably the examining doctor did not take into account the impact the clients' headaches had on his ability to carry out the functional activities.

At the tribunal the adviser submitted the EMP report and argued that the many inconsistencies were indicative of the overall poor performance of some examining doctors. The tribunal accepted that inconsistencies did exist and as a result they adjourned the tribunal in order to gain an independent assessment.

The report was made available on 9/11/00 and in conclusion the orthopaedic consultant stated the client was compromised in sitting, getting up from sitting and standing for any length of time. He was advised to refrain from bending, lifting and carrying. Significant difficulties with walking were also confirmed. This report seemed to confirm the findings of the EMP.

This case highlights some of the inaccurate/inconsistent reports compiled by MSS. Luckily the adviser was able to produce evidence of this due to the close proximity of both examinations. Unfortunately it is often difficult to discredit medical reports without strong evidence. Therefore genuine clients are losing benefit due to misleading reports.
It is also worth noting that the client’s failure to satisfy the All Work Test triggered a review of his DLA. However, his award was upheld.

**Doctors attitudes**

A **Craigavon** client had been receiving high rate mobility, middle rate care. The client is a lone parent on IS with a severe disability premium in payment. On renewal an EMP visit was arranged (Mar 01). The client recognised the EMP from a visit 5 years previous when she first applied. That application had been refused.

The EMP looked at her kitchen wallpaper and commented that she had the kitchen decorated since his first visit. He asked rhetorical questions and when leaving he suggested that she might dress rather than wear pyjamas for any future visit. The client suffers from severe depression, suicidal tendencies, sarcydosis of lungs, arthritis and stress. The examination lasted no longer than 15 – 20 minutes.

An **Omagh** client suffered from M E which affected him both physically and mentally. Following a medical assessment on 2/2/00 he was found capable of work. In the decision it stated that he scored 4 points for mental health but had no significant limitations with respect to the physical descriptors.

On examination of the case papers it transpired that despite the fact that the examining doctor was aware of a diagnosis of ME he did not consider the client’s inability with relation to the physical descriptors. In not considering the physical descriptors he recorded “on examination the client has no physical symptoms of pain or stiffness, had good spinal, upper and lower limb movement. Straight leg raising was full and he had good power reflexes”. He went on to record that “there was no evidence of physical problems”.

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Over recent years there has been substantial medical debate concerning ME, CFS and whether they are physical or mental health problems. Social security caselaw recognises they have both a physical and mental aspect and that both should be taken into consideration for benefit purposes. In the Incapacity Benefit Handbook for approved doctors Chapter 17 contains guidance for doctors when presented with such cases. At Part 5 it states that as a rule there are no abnormal clinical signs, except in rare cases where prolonged immobility has resulted in muscle wasting. Chapter 17 gives a comprehensive insight into the problems associated with M.E. and having read it the adviser was of the opinion that the doctor who had examined the client on 2/2/00 had ignored the guidelines contained in the Handbook.

At the tribunal the adviser argued that the decision to disallow benefit was unsafe as the examining doctor had clearly breached the guidelines in not applying the physical descriptors. The tribunal accepted the arguments and proceeded to ask the client questions relating to his physical problems. The appeal was allowed and the client scored a total of 18 points, 9 of which were awarded for physical problems. This case highlights the continued confusion surrounding these particular illnesses and medical attitudes to them. The Alliance is concerned about how clients presenting with ME or CFS are assessed by doctors.

In the past year the adviser found they did not receive as many complaints or feedback from clients who had either experienced the Personal Capability Test or had a visit from a Medical Examiner from Disability Living Allowance. Prior to this the adviser found that the levels of anxiety endured by people who were called for an interview or examination, both beforehand in anticipation of the interview and in their experiences during the interviews, were high due to the attitude of the doctor. This varied from brusqueness, an unsympathetic approach in some cases to just downright rudeness. Some said they were made to feel as if they were lying about their condition and were not genuine in their claim for benefits.
A Belfast client was disallowed ICB in January 2001 following an examination. The client suffers from depression and chronic anxiety according to the medical evidence from his GP. When examined by a MO, the client felt that he was being asked questions in such a manner that his first answer was not being accepted. In fact the client said he had to keep giving answers until he said something that the doctor accepted. He felt badgered by this manner of questioning.

The client attends NICAS for counselling. The doctor wrote on his report that he did not believe the client’s account of attending NICAS. He also wrote that due to the labels being ripped and torn on the client’s medication he did not believe they belonged to him. Due to the doctor’s manner the client did not feel he could really explain his situation. At the tribunal the chairman commented on the “assumptions” and “scepticism” of this doctor. The client’s ICB claim was allowed on appeal.

The client is 21 years old and has had a difficult life so far. He was very upset at the doctor’s disbelief of his illness. Someone with mental health problems needs to be handled sensitively and to be dealt with in a reassuring manner. The adviser questioned this doctor’s beliefs as it is clear all he is interested in is getting people off benefit.

A Newtownards client with mental health problems was grieving for his mother and sister both of whom died of cancer within a short time of each other. The client had nursed them both. He claimed incapacity benefit and was examined by a doctor for this benefit. The adviser assisted the client with the completion of DLA forms. The client came back to the adviser visibly panicked asking to stop the claim as he had received a letter telling him the doctor would be calling. The client stated “I will not be put through anything like that by one of those people ever again”.

The client would rather not have the money if it meant a doctor calling and examining him. He said “The doctor did not upset me deliberately, he was just so thick skinned and insensitive he did not realise what he was doing to me.
It left me a wreck for a couple of days, crying and unable to get out of bed. He was patronising and totally undermined the grief I feel”. The adviser cancelled the doctor’s visit and DLA Branch is to request a report from his psychiatrist.

A female Belfast client aged 57 suffered from hypertension, asthma, ear drum perforation, permanent hearing loss, depression and anxiety. The client was raped in 1998 and attends counselling. The client attended a medical at Royston House – 8 points awarded for hearing loss only. The examining doctor noted that the client’s hands very red from housework, she had neat, tidy hair and her nails were tended. The examining doctor also noted that the client was bright and alert, had no hint of mental illness and concentrated very well throughout test. No points were awarded for mental health despite the client having provided information on her personal assault and rape and the impact this subsequently has had on her mental health.

On appeal the client was awarded sufficient points on mental health to allow the case. The client felt that remarks made by the examining doctor were inappropriate and inaccurate. Throughout the examination the client was unable to hear what the doctor was saying because of her hearing loss.

Another Belfast client failed the Personal Capability Assessment – 9 points on physical, 4 on mental health. An examination took place on 28/9/00. The decision was overturned on appeal on 13/2/01 with 9 points awarded for both physical and mental descriptors. The doctor wrote on IB85 – Box 57 medical evidence in support of the opinions above: “neat and tidy, hair dyed and well-groomed, cursed at times”…. The client does not dye her hair!

A Dungannon client applied for DLA and was turned down. She was visited by an EMP. On dressing he wrote “could manage herself if she only wore appropriate clothing!”

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A Lisburn client applied for ICB. In the examination the doctor made an issue of the fact that the client had “callouses on feet” even though the basis of the claim was on mental health grounds, i.e. the doctor did not refer to the relevant descriptors.

A Belfast client required help filling in his DLA forms. He received notification of an EMP visit and subsequently, he was disallowed. He contacted the adviser again for help to appeal. He informed the adviser that the EMP questioned him at length about his employment and asked the client if he did not want the fact that he worked mentioned. The client asked why this was suggested as he had been informed by the adviser that it was possible to work and claim DLA.

The EMP said “Oh, so you don’t want me to say that you work.” The client felt that the EMP was implying that he had no right to work and claim DLA and he does not want to complain in case it jeopardises his appeal.

A Coleraine client was refused DLA and requested an appeal after an unsuccessful attempt to get them to look at the decision again. She was visited by an EMP, who made inappropriate comments regarding her home and furnishings. The client was asked to do mental arithmetic and was asked inappropriate questions. The client was bewildered, upset and embarrassed by the whole experience.

A Holywood client who suffered from osteoarthritis, diabetes and depression was visited by an EMP. He was on low rate care, high rate mobility. The doctor insisted that he examine the client upstairs despite the client objecting due to difficulties with the stairs. The client dragged himself up the stairs for the examination.

A Dungannon client suffers from lower back pain and muscle spasms. While being examined by an EMP, he put his hand on her back and she jerked in pain. The doctor said, “I am sure that you let your boyfriend touch you there”. The client scored 16 points and won the tribunal.
A Portadown client was examined by an EMP who made a number of irrelevant comments, e.g. about the client’s previous occupation in the armed forces. He asked questions about whether the client was armed, if the house was protected, if his life was in danger. The client now realises that he signed page 3 of the report agreeing with the information in the report, etc. The client insists that the report was not read back to him and he was simply asked to sign his name. The client is disputing numerous comments made by the EMP. A letter has been sent to the complaints officer at MSS. Client is not satisfied with the response received. The client will make a further complaint to the Chief Executive of SSA and the Independent Case Examiner.

An Armagh advice centre represented at three ICB appeals within ten days. There were significant inaccuracies in all three EMP reports and several examples of false statements. Two cases stated that clients lived in two-storied houses. Neither client lives in two storied accommodation and both state that they were not asked that question. In one case the doctor stated, “no appointments with a psychiatrist”. The client had shown the EMP a letter of appointment with a psychologist. This was not mentioned.

In one case, the panel doctor questioned a remark made by the EMP and asked the presenting officer for his comments.

An East Belfast client suffering from a chronic depressive illness and CFS met the criteria for PCA. The client had three examinations at Royston House. One of these went without incident, but the client felt that the MOs were abrupt and cold in the other examinations.

A Newry client made a claim for DLA. The client had a road traffic accident in 1992 and suffered from neck/shoulder/back pain, chronic breathing problems, hypertension and depression.
The EMP Report was requested. The entire tone of report is one of scepticism, some of the remarks include:

“just before listening to his chest – unexpectedly took bout of coughing – very forced and wretched a bit”
“initially pleasant then became irritated due to detailed questions”

The client informed the adviser that there was an argument about using a bottle in which to pass urine. He had never been advised of this. The doctor thought he should be using one and could not understand why he was not and so therefore the client became frustrated with the line of questioning.

The phrases “physical factors are not in keeping with any of stated needs” and “very high degree of overlay, etc.” are commonly used by this medical officer. An unusual aspect of this report is that the medical officer inserted an extra piece of paper. Obviously the Medical Officer believed that the client would not have access to this. He was launching a pre-emptive strike by making reference to a possible complaint from the client. This report and numerous others indicates the lack of impartiality, and the judgmental attitude of this Medical Officer. Clients cannot be assured of a fair report on their condition and related care mobility needs. The client is particularly angry at the statement,

“More into desired needs rather than required, quite demanding to his wife.”
A Derry client claimed incapacity benefit from 1/5/00 by reason of dermatitis and completed the IB50 questionnaire on 29/8/00 and was examined by a MO on 22/11/00. She was only awarded 8 points for descriptor 8(d) (Cannot pick up and carry a 2.5 kilogram bag of potatoes with either hand) and failed the personal capability assessment. The client contended she should have scored 15 points for descriptor 7(b) manual dexterity and 15 points for descriptor 8(c) lifting/carrying. The appeal was lodged on 22/12/00 and the case heard on 30/4/01.

In awarding 8 points under descriptor 8(d) (cannot lift potatoes with either hand) the MO had concluded that the client should be able to lift lighter weights such as the saucepan/kettle (8(c)). The MO noted that the client had poor grip power in both hands “painful hands” and that the dermatitis affected exterior surfaces and webs of all fingers with redness, dryness and slight eczema. The MO under the typical day category noted that the client couldn’t lift a kettle, couldn’t carry shopping bags and that her son prepared her dinner for her.

It was submitted to the tribunal that the MO had applied the wrong test in assessing manual dexterity and lifting and carrying. The MO should have considered the function of the wrists/hands and the ability to grip and perform fine manipulation and that the task needed to be done reliably, safely at reasonable speed and could be repeated. The MO should have also considered power, co-ordination and joint mobility in the hands, wrists and upper limbs.

The MO had clearly made his choice based on the weight of the object, i.e. potatoes versus kettle/saucepan instead of applying the correct criteria. It was pointed out to the tribunal that the saucepan/kettle was only 1lb lighter than the potatoes. The MO clearly had not considered grip/power joint mobility, etc.
It was further explained to the tribunal that the client had an award of lower rate care component DLA for being unable to prepare a cooked main meal, i.e. could not cope with saucepans kettle or peel/chop vegetables/potatoes.

The tribunal awarded 15 points for descriptor 8(c), i.e. cannot pick up and pour from a saucepan or kettle of 1.7 litre capacity with either hand.

A Derry client claimed ICB due to physical problems. He also suffered from severe bouts of depression. He was examined and awarded 0 points. The medical officer failed to note any of the mental problems experienced by the client during the examination. On the morning of the appeal, the client was forcibly admitted to a local hospital in a manic state, suffering from bi-polar affective disorder. He spent the next 13 weeks in hospital detained under the Mental Health Order. The tribunal awarded 13 points on mental descriptors alone.

Complaints

A Newtownards client aged 60 put in a claim for DLA. The client is housebound, very ill, gets meals on wheels, is visited by care workers, etc. The EMPs report resulted in the client being turned down for DLA. The client received a phone call asking for directions to his house. The caller did not state who he was - he only identified himself when he asked the client to get on the settee and remove his trousers. The client said he was patronised and treated brusquely and was subjected to a painful examination. The adviser submitted a letter of complaint for the client. The reply stated the client was not treated like this and no apology was given.
A **Belfast** client suffered with Polyneuropathy/Epiconclylitis, contact dermatitis, varicose veins, reactive depression, and angina following heart attack in 1998. The client failed the PCA. The doctor at Royston House assumed that the client was not taking his medication and awarded no points.

The client was examined by the EMO at Royston House in January. The client had his medication with him. However when the client gets his repeat prescriptions he tops up his medicine bottles for ease of access and to avoid confusion. The doctor did not ask the client why the dispensary dates were different. He noted that the labels were stained and assumed the client was not taking his medication. His report was therefore based on the assumption that client was not taking his medication. The following discrepancies were noted in the report.

1. The doctor stated the examination lasted for 40 minutes, the client states it lasted for 15 minutes maximum.
2. The doctor stated that the client’s daughter comes over to his house and makes him breakfast. The client’s daughter rarely visits as the client’s wife is severely mentally and physically disabled and spends the day shouting and screaming - the daughter finds this distressing.
3. The doctor stated the client used steps with ease to mount the couch – the client did not have to use steps to get onto couch, given his height.
4. The doctor stated the client used his hands “with clothes” the client was not asked to undress at any time during the examination.
5. The doctor stated the client reads/reads lots/reads to wife – the client does not get sufficient quiet to read at home given his wife’s behavioural problems. He does not read to his wife, as she would not understand.
6. The client attended the examination with his wife’s care nurse – the doctor underlined nurse and followed it with exclamation mark, i.e. nurse!

7. The doctor stated the client’s presentation ‘was glib’, the client suffers from reactive depression and had excellent medical evidence.

8. The client scored no points and an appeal was lodged in April. Prior to his hearing he was awarded DLA (high rate mobility/low care rate) and this was backdated to January.

9. At the hearing the client’s benefit was re-instated.

10. The IB85 was very difficult to read

A Lurgan client was claiming ICB for seven years. She came off ICB and started a part-time job. She became unwell and was not entitled to SSP. The client then left the job and is unwilling to claim ICB again as she feels that the stress of medical examinations and form filling may make her condition deteriorate.

A Coleraine advice centre had several clients going from no points or very low points to qualifying points for Incapacity Benefit at tribunal. This is an indication that independent adjudicators do not always support the findings of Medical Officers.

A Holywood client suffering from dizziness, tinnitus, open angle glaucoma, renal sores and chronic anxiety was awarded 4 points for mental descriptors and 0 for physical after an examination for ICB. At the tribunal, a doctor and legally qualified chairman asked to consider physical descriptors in the first instance and then, if necessary, look at mental descriptors. The client was awarded 23 points for physical descriptors alone and their benefit was reinstated
4. Recommendations

- Medical Support Services (MSS) should address the issues of delays in medical examinations and the failure to keep appointments. This should be constantly monitored by MSS and the Chief Executive’s Office of the Social Security Agency (SSA) to ensure minimum disruption.

- Medical Officers should be instructed to produce legible medical reports as these reports are an important part of the decision making process by SSA decision makers and appeal tribunals. Illegible reports should be made available in a transcribed and original format.

- Sufficient time should be allocated to all medical examinations. Extra time should be allocated to Personal Capability Assessment (PCA) examinations involving both physical and mental issues.

- Frequent inaccuracies in medical reports should be addressed.

- Medical Officers should undergo more training to ensure a better understanding of descriptors and that greater consistency can be achieved.

- A more robust monitoring system should be introduced to ensure that examinations are being conducted without prejudice or personal opinion. Any monitoring system should take into account customer’s views.

- Customers should be better informed about MSS complaints procedure. Leaflets should be available in advice centres, social security offices and benefit shops. More reference should be made to this procedure in MSS correspondence.
# Appendix 1 – MSS professional Standards

## Medical Support Service
### Professional Standards - Customer Service

<table>
<thead>
<tr>
<th>MSS Function</th>
<th>Standard</th>
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| **Carrying out examinations** | - To act accordingly to the SSA Equal Opportunities Policy  
- To make the customer feel welcome and to feel at ease  
- To introduce oneself to the customer  
- To be polite at all times  
- To encourage a person accompanying the customer to be present during the examination if so desired by the customer  
- To allow the customer time to give their history, asking any questions in a non-adversarial manner  
- To explain the purpose of the examination  
- To explain what the examination entails  
- To carry out the examination gently to avoid any unnecessary discomfort to the customer  
- To carry out a relevant examination to provide the information necessary for adjudication  
- To answer questions posed by the customer, without compromising any subsequent adjudication process |

## Disability Allowance & Attendance Allowance: EMP reports

| EMP must be:            | - Presentable in appearance  
- Courteous in approach  
- Punctual |
|-------------------------|-----------------------------------------------------------------------------------------------|
| Reports must:           | - Be legible  
- Be comprehensive  
- Be consistent within themselves  
- Be impartial  
- Be clearly understandable  
- Be medically correct  
- Not make any reference to entitlement |
Professional Standards
Incapacity Benefit

<table>
<thead>
<tr>
<th>MSS Function</th>
<th>Standard</th>
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</thead>
</table>
| 1. Personal Conduct        | Accessible
|                            | Punctual
|                            | Reliable
|                            | Presentable
|                            | Approachable
|                            | Courteous
|                            | Friendly
|                            | Helpful
|                            | Be aware of and apply relevant MSS standards                           |
| 2. Carrying out examinations| To act in accordance with the Equal Opportunities Policy               |
|                            | To make the customer welcome and feel at ease*                         |
|                            | To introduce oneself to the customer                                  |
|                            | To be polite at all times                                              |
|                            | To encourage a person accompanying the customer to be present during the examination if so desired by the customer |
|                            | To allow the customer time to give their history, asking questions in a non-adversarial manner* |
|                            | To explain the purpose of the examination*                            |
|                            | To explain what the examination entails*                               |
|                            | To carry out the examination gently to avoid any unnecessary discomfort to the customer |
|                            | To carry out a relevant examination to provide the information necessary for adjudication |
|                            | To answer questions posed by the customer as fully as possible without compromising any subsequent adjudication process* |

NB: *time constraints of assessment are recognised when undertaking these activities.
Appendix 2 – Respondents to consultation exercise

Age Concern, Castlederg
Ards CAB
Armagh CAB
Ballynafeigh Community Development Association
Bangor CAB
Churches Advice Centre, Derry
Coleraine CAB
Craigavon Independent Advice Centre
Derry CAB
Disability Action, Dungannon
Dungannon CAB
East Belfast CAB
East Belfast Independent Advice Centre
Falls CAB
Holywood CAB
Lisburn Welfare Rights
Lower North Belfast Community Council
Newry CAB
Newry Welfare Rights
Omagh Independent Advice Services
Portadown CAB
Suffolk & Andersonstown CAB