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GUIDANCE ON ILL HEALTH RETIREMENT

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SUMMARY

Doctors are increasingly being asked by their patients to provide a report in support of an application for them to retire from work on the grounds of ill health. There is evidence that some applications may be motivated more by financial incentives than by ill health. Doctors should be wary of a conflict of interest, know the pension company's criteria for ill health retirement and provide objective medical evidence. The decision as to whether the patient fulfils the criteria is best left to another doctor who is acting as an advisor to the pension company.

KEY WORDS: Ill health retirement, Rheumatic diseases, Pension rights.

PATIENTS with rheumatic diseases often find themselves unable to continue their occupation owing to their disability. The legal implications of a patient continuing to work when affected by rheumatic diseases are addressed later in this series of articles. This paper discusses the role of the specialist and the occupational physician in supporting an application for ill health retirement and, in particular, considers the pension rights of the patient, and alternatives to retirement.

TRENDS IN ILL HEALTH RETIREMENT

The rate of retirement from work on grounds of ill health has increased over the last few decades in several organizations. In the NHS, this increase was most marked in the early 1990s (Table I), and the recent fall is almost certainly due to the entry of part-time workers into the scheme. In those organizations where premature retirement (usually for those over age 50 yr) or voluntary redundancy are also available to employees, this rate too has been seen to increase, in association with a corresponding fall in the rate of normal age (65) retirement [1]. The pressures of contemporary management styles are partially responsible for these trends, but occupational pension and State benefits offer incentives too. For example, a roadworker in the Local Government pension scheme, retiring on the grounds of ill health after 25 yr of service on a final salary of £250 per week, can expect a lump sum of £16 500 and an index-linked annual pension of £105 per week. To this the State may add Incapacity Benefit and a Disabled Living Allowance of up to £138, making a total of £243 per week, which is very close to what the patient was previously earning.

There is evidence that some pension schemes are being manipulated by members to achieve enhanced benefits (Fig. 1). In this organization, enhancement in benefits is payable after 5 yr of service, there being no medical reason why illness should peak at this time. Evidence of benefit deceit also comes from a study of

patients who had undergone coronary artery bypass grafting (CABG) which showed that the proportion with abnormal ECGs was no different in those who retired from work compared with those who returned to work [2]. A questionnaire survey of another group of patients who had previous CABG showed that most retired for social, financial or psychological reasons rather than for medical indications [3].

CRITERIA FOR PENSION BENEFITS

Doctors from all disciplines are frequently asked to prepare reports to support early retirement. It is essential before advising a patient on whether retirement on the grounds of ill health is possible that the written criteria of the patient's pension scheme be examined. Pension scheme criteria for granting ill-health retirement benefits vary from being very strict, demanding that the patient shows permanent incapacity to undertake any form of remunerated work, to lenient, where the employee suffers ill health which prevents him from regularly and effectively undertaking his current duties.

Local Government and NHS pension schemes require the applicant to have permanent ill health (i.e. illness which will last until the age of 65 yr) which will prevent the patient from doing his normal job. In practice, the key components of any criteria are whether the ill health must be permanent, and whether incapacity refers to other jobs or only the particular job being done at the time the applicant became ill. If the pension scheme criteria are very strict, one may need to state that the patient will never work again. Clearly, this may well be impossible to judge with diseases such as inflammatory arthropathies or connective-tissue diseases, where the clinical course is unpredictable. It must also be decided whether the patient is unable to perform the duties for which he was most recently employed, as it may be possible for other duties to be assigned or for the patient's hours of work to be

TABLE I

Rates of normal age (65 yr) and ill-health retirement per 10 000 contributing members (1987–1996) for the NHS Pension Scheme

Year	Normal age	Ill health
1987/88	140	89
1988/89	149	89
1989/90	156	90
1990/91	156	96
1991/92	167	100
1992/93	176	114
1993/94	161	131
1994/95	150	119
1995/96	153	102

changed. Many companies are prepared to co-operate with this rehabilitation process and this may well affect the ability to retire on health grounds. No opinion should be given until the doctor has the criteria in writing from the pension company. Effective communication between occupational physician, general practitioner, the specialist and, of course, the patient is essential.

Employees who are ill yet do not fulfil the criteria for ill-health retirement with a pension, but who are unable to return to work after a reasonable period of absence, may be dismissed by management on the grounds that they are incapable of fulfilling the terms of their contract of employment. In this case, they will not receive their occupational pension until their normal age of retirement, which can be anywhere between 50 and 65 yr depending on the rules of the pension scheme. In this situation, financial incentives in the form of voluntary redundancy may also be available to

the employee, but this is a management decision arising from reorganization of the work.

CONFLICT OF INTEREST

A doctor asked by a pension company for an opinion about whether a patient under his or her care fulfils the criteria for ill-health retirement should be wary of any conflict of interest. This situation is likely to occur if the doctor is the individual's general practitioner or specialist, when giving an impartial and objective opinion may not be in the patient's best interest and may possibly compromise the doctor-patient relationship. The pension company should be told that their request could create a conflict of interest and that, if required, only a factual report about the history, examination and results of investigations can be provided. The judgement about whether the patient fulfils the criteria should then be left to an independent doctor, such as an occupational health physician who does not have continuing or therapeutic responsibility for the patient. They would then be acting on behalf of the pension scheme trustees or administrators. It is also important to know whether the report is intended for a lay or medical readership as this should influence the style and content of the report.

Written consent from the patient to write to the pension company should be obtained since the Access to Medical Reports Act (1988) will apply. This gives the patient the right to see the report before it is sent. The patient may agree to the report being issued unchanged, ask that a statement setting out his or her views is attached to the report, or withdraw consent for the report to be sent. The doctor is not obliged to let the patient see any part of the report that in his or her

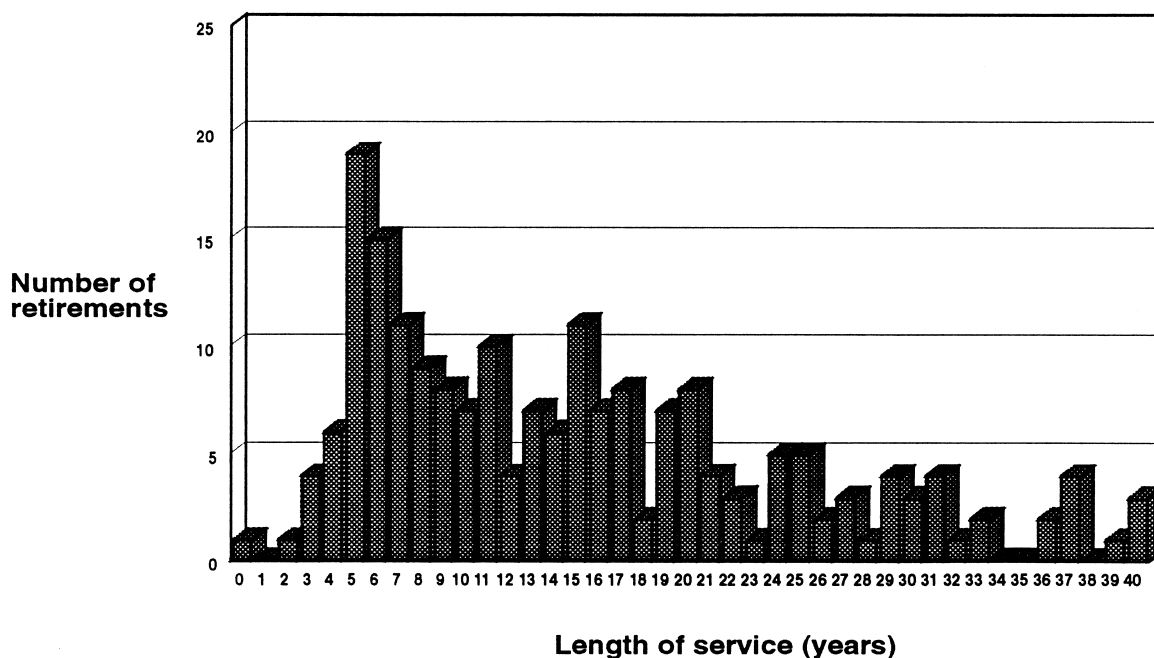


FIG. 1.—Number of ill-health retirements by length of service (1994–5) in a large organization with mode at 5 yr which coincides with an enhancement in benefits.

opinion would be likely to cause serious physical or mental harm to the patient, indicate the doctor's intentions towards the patient or reveal information about others who may not have given their consent.

OBJECTIVE ASSESSMENT

In arriving at a decision as to whether a patient fulfils the criteria for ill-health retirement, the natural history of the disease, the therapeutic options that have been tried and, where available, the results of longitudinal studies for features of the illness which are associated with a poor prognosis are all relevant to a decision about fitness to work. Surrogate measures of functional ability at work, such as grip strength using a dynamometer, exercise tolerance from a treadmill test, the ability to drive a car or partake in a particular hobby or sport are also helpful. It is important to know exactly what is involved in the post, particularly the physical demands and skills required. One must objectively assess whether the patient's illness is likely to be aggravated by his current duties, and also whether the condition poses any risk to other workers.

Lack of motivation, inter-personal conflicts with colleagues, concurrent depression and medico-legal issues may all prevent successful rehabilitation of the patient back to work. Such factors should be identified and made explicit to the trustees of the pension scheme. All doctors should work to guidelines to ensure objective judgements about whether a patient fulfils the criteria for ill health retirement are made. Some applications for benefits are difficult to assess and examples of such illnesses which most frequently come under the care of a rheumatologist are given below.

CHRONIC FATIGUE SYNDROME AND FIBROMYALGIA

There have been a few longitudinal studies published recently of patients with chronic fatigue or chronic fatigue syndrome [4–6]. Although follow-up has been for no longer than 4 yr, 60–70% of patients have made a good functional recovery. In two studies, 66–70% of patients improved sufficiently to be able to return to their work and functional impairment fell with increasing length of follow-up. A belief by the patient that an undiagnosed physical illness was responsible for their illness, or the presence of a primary psychiatric diagnosis, are features associated with a poor prognosis. A cognitive-behavioural approach to management of the illness has been shown to be effective [7, 8]. Dysfunctional thoughts should be addressed and a programme of graded activities with the objective of returning the patient to normal functioning recommended, rather than periods of prolonged inactivity. Psychiatric referral may be helpful for those who fail to respond to rehabilitation or for those with predominantly psychiatric symptoms but a recent trial of fluoxetine was no better than placebo [9]. If the criterion for ill health retirement specifies permanent ill health, then the majority of patients will not qualify, whereas if it is only for the

next year or two, then the application is likely to be successful. Patients suffering from fibromyalgia who have a high tender joint count, mental ill health, fatigue, a low educational achievement or who are pursuing compensation have the worst prognosis [10, 11]. Again, if the criterion for ill health retirement is permanent ill health, then the majority of patients are unlikely to qualify.

BACK PAIN

In the absence of neurological symptoms and signs, early mobilization within the limits of the pain and early return to work are recommended now in preference to prolonged bed rest or inactivity [12]. For those patients with chronic or severe mechanical back pain, treatment by chiropractic manipulation has been shown to result in better outcome measures than conventional hospital out-patient management [13]. Strategies which address negative beliefs by the patient, such as work being detrimental to their backs, whilst at the same time promoting a positive attitude towards controlling back pain, have also been recommended [14]. Patients with back pain, mental ill health, prolonged sickness absence, poor job satisfaction and who are pursuing compensation have the worst prognosis [15]. Degenerative changes on X-ray in keeping with the patient's age, or disc bulges and protrusions (but not prolapses), are equally prevalent in people without back pain and should not be a reason to support retirement on health grounds [16, 17].

ADAPTIVE TECHNOLOGY

An occupational physician asked to assess a request for ill-health retirement should be able to assess the workplace and, if appropriate, facilitate changes in the work pattern or arrange for adaptive technology to be introduced. If the patient is unaware of such a doctor at their place of work, then a local NHS Occupational Physician or Employment Medical Advisor from the Health and Safety Executive should be available to see the patient and arrange to visit the workplace. A grant of up to £21 000 over 5 yr is available from the Employment Service to meet the cost of adaptive technology or aids for disabled people at work or planning to return to work. A doctor can refer a patient to the service via the local Disability Employment Advisor at a Job Centre [18].

SUMMARY

Doctors who are asked to write reports to pension companies should know the criteria for awarding pension benefits and should be wary of potential conflicts of interest with their patients. Only objective medical evidence should be supplied, which in turn should be assessed by a doctor with training in occupational health, who is independent from the patient's employer. The decision as to whether the applicant fulfils the criteria for ill health retirement is often best made by this doctor, who is acting as an

advisor to the pension company, and not by the patient's general practitioner or specialist.

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