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Medical sickness certification: why not review the role of the general practitioner?

GENERAL practitioners play the central role in enabling patients to claim sickness benefit. Statistics on the geographical variation in claims for sickness benefit from region to region are available from the Department of Social Security.[1] Figures on new claims indicate a gradual decline between 1982 and 1988. This may indicate that claims due to sickness and invalidity tend to fall if work prospects improve. High unemployment and local economic decline are factors which lead to an increase in sickness certification.[2]

Time constraints in general practice are complex and changing. The new contract imposes increased demands on the time available to general practitioners actually to consult with patients. Is the continuing responsibility for issuing medical certification still necessary or appropriate? The transaction has for the most part become one of benevolent support by doctors for their patients. The new contract encourages the expansion of list sizes and could make general practitioners less willing to confront patients. This area is one of potential conflict.[3]

The nature of requests for medical sickness certification has changed and I suspect that many families view sickness benefit as an essential element in the family income. Women who have joined the national workforce in the last 20 years have changed the patterns of claims. It is not unusual to be issuing medical certificates to a man whose spouse is in full time employment. Many women receive sickness benefit in the postnatal period and are reluctant to dismiss symptoms lightly if challenged. The shape of our society is changing and the administrative response to assessing sickness benefit claims needs a radical review. Doctors have tried very hard within the National Health Service to ensure a uniform standard of care irrespective of class and social status. The work of Crombie[4] suggests that any deficiency that might exist by social class[5] in the use of health services is most likely due to their own underuse of the services and is not due to the general practitioner's diminished responses to the patient's initiatives. Social factors are not within our overall power to change, but we share the burden of their consequences.[5] The government could lessen this burden on general practice if there were a system of independently reviewing claims for certification. Present arrangements are flawed.[6]

If the present system services the needs of the Department of Social Security then one can only postulate that the department tolerates standards which are less than excellent. The transaction, whereby the general practitioner provides a slip of paper, opens the door to a financial resource which exceeds expenditure on drug prescribing. The total cost of NHS prescriptions dispensed by the chemist and appliance contractors was a little over £2.5 billion in 1988.[7] Invalidity benefit paid to those incapable of work because of long term sickness was £3.41 billion in the financial year 1988–89.[8]

The method for examining present claims by a third party is also in need of scrutiny. If a patient has been off work for a period of time the general practitioner may be asked to complete an RM2 form which requests a brief medical history, a comment on the patient's present condition and their fitness to attend a medical examination

centre. Most doctors are unaware of the criteria used by the regional medical officer in deciding which patients are to be called for examination. The completed forms are apparently hand written and variable in content. This report is an important marker as it influences the decision whether to send for the patient. A poor report increases the chances of a patient's case being assessed independently. The present RM2 forms often frustrate the general practitioners who are asked to complete them and the regional medical officer involved in their analysis.

The greatest demands on the issuing of medical certificates are likely to take place in those practices which already have a high workload.[9] The government may consider that any major change in assessing people for sickness benefit is potentially more expensive than the present system. As in many other areas of health care good quality and cheap services may not be harmonious bedfellows.

We are at present undergoing a review of resources as applied to the health service. Is the present system cost effective? Family doctors are unaware of the cost of the present system and receive virtually no education about how to assess patients in relation to their occupation. We lack knowledge of how benefit schemes are managed and administered. Certification does not appear to be a highly valued activity by general practitioners themselves and is not appreciated by patients and civil servants. The time has come to review present arrangements.

General practitioners often express anxiety when they seem likely to lose part of the service they offer to patients. Any suggestion that specialists should move into primary care assessment is met with a vigorous opposition by generalists. Would general practice be diminished if we were excluded from assessing our patients' inability to work? Some general practitioners might see this activity as a major responsibility which could not be divorced from the rest of our contractual obligations.

I suggest that assessing patients for claims on sickness benefit is for the most part removed from the working obligations of the general practitioner. I also suggest that the patient takes the main responsibility for registering sickness. The employer may wish to make arrangements for assessment, but in the event of state benefits being claimed over a set period of time a full assessment is performed by an independent panel. This initiative could considerably modify the nature of general practice consultations for many doctors who could offer a better service to their patients as a result of the changes.

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References

1. Department of Social Security. *Social security statistics.* Norwich: HMSO, 1989.
2. Yuen P, Balarajan R. Unemployment and patterns of consultation with the general practitioner. *Br Med J* 1989; **298:** 1212-1214.
3. Ellsbury KE. Controversies in family practice. *J Fam Pract* 1989; **28:** 698-704.
4. Crombie DC. *Social class and health status: inequality or difference. Occasional paper 25.* London: RCGP, 1984.
5. Carstairs V, Morris R. Deprivation: explaining differences in mortality between Scotland and England and Wales. *Br Med J* 1989. **299:** 886-889.
6. British Medical Association General Medical Services Committee. Advice on the provision of medical certificates under Social Security Acts. In: *Annual report 1986.* London: BMA, 1986. Appendix XI: 52.
7. Office of Health Economics. *Compendium of health statistics (7th edition).* London: Office of Health Economics, 1989.
8. National Audit Office. *Invalidity benefit: report by the comptroller and auditor general.* London: HMSO, 1989.
9. Beale N, Nethercott S. Job-loss and family morbidity: a study of factory closure. *J R Coll Gen Pract* 1985; **35:** 510-514.

Zoonoses — a suitable case for research?

ANIMAL transmitted disease has occupied the headlines perhaps too often for comfort recently. Politicians have suffered, and public concern about the problem has been increased by poor quality information in the media and from self appointed 'experts'.

Zoonoses are 'infectious diseases naturally transmissible between vertebrates and man'.[1] At least 150 are recognized worldwide,[2] and about 40 can cause problems for people in certain occupations.[3] They are recognized as a major economic and health problem by government health departments, employers and the World Health Organization.[4] The diseases range from common tropical helminthiases, such as ankylostomiasis, to rare viral conditions of high mortality, such as Lassa fever. In the United Kingdom current concern focuses on gastrointestinal illnesses — salmonellosis, listeriosis and campylobacteriosis — and their effect on elderly or pregnant patients, and on leisure related illnesses including leptospirosis icterohaemorraghiae (in canoeists and cavers) and cryptosporidiosis (in children visiting farms). Disease spread by domestic animals such as toxocariasis from dogs, and toxoplasmosis from cats is also of concern.[5,6]

The incidence of zoonotic disease in the UK is unknown but the numbers of confirmed cases of 'common' zoonoses are shown in Table 1. The numbers are small, but the usual caveats associated with underreporting apply.

People in certain occupations are known to be at increased risk — veterinarians[7] from various infections including ringworm, orf and Q fever; dairy workers[8,9] from *Leptospira hardjo* and cryptosporidia infection; and food handlers[10,11] from salmonellosis and infection by other gastrointestinal organisms. Forestry workers[12] often show evidence of past *Borrelia burgdorferi* infection, but little evidence of overt Lyme disease. There are anecdotal reports of high rates of tick bites in foresters and park rangers in areas of substantial deer population, but no evidence of increased illness at present. Gamekeepers, agricultural workers, field course teachers and playing field maintenance staff all report regular contamination with animal faeces, products and carcases, and their representative bodies are requesting research into the problems of occupationally related illness. Visitors to country areas may be at extra risk in national parks where a high wild animal population exists.[13]

Pregnant women involved with lambing, often as part of a husband and wife sheep farming team which is common in many hill areas of the UK, are known to be at risk of miscarriage from *Chlamydia psittaci* infection in lambing ewes.[14-16] In a press release the Health and Safety Executive strongly advised pregnant women to avoid close contact with sheep particularly during lambing,[17] advice which can cause considerable difficulty for many small farmers.

Participation in water sports can result in exposure to various infections including leptospirosis, gastrointestinal distur-