



Incapacity benefit reform and the politics of ill health

PERSONAL VIEW **Clare I Bamba**

In October 2008 incapacity benefit in the United Kingdom will be replaced, for new but not existing claimants, by the employment support allowance.

This radical change has been largely ignored by health professionals, despite the role of general practitioners in the diagnosis and certification of long term sickness absence, the involvement of the NHS (usually via primary care) in interventions for getting incapacity benefit claimants back to work (notably the condition management programme and Pathways to Work), and the importance of income maintenance policies for the health of individuals and the population. But the reform of incapacity benefit signifies a dangerous political shift in how chronically ill and disabled patients are seen as either “deserving” or “undeserving” of state support. Such a shift will have important implications for the health professionals involved.

Incapacity benefit, the main social security cash benefit that isn't means tested, is paid to 2.7 million people in the UK. Recipients, who need to have contributed sufficient national insurance payments, are assessed as being incapable of work because of illness or disability, initially by a GP and after six months by a Benefits Agency doctor. There

Healthcare workers will become increasingly involved in regulating the poor

are two short term rates: a lower rate paid for the first 28 weeks of sickness (currently £63.75 (€80; \$120) a week) and a higher rate for weeks 29 to 52 (£75.40 a week). A long term rate (£84.50 a week) applies to people

who have been sick for more than a year and accounts for the largest number of claimants. Participation in employability programmes is voluntary for claimants of incapacity benefit.

The new employment support allowance will comprise a two tier system of benefits in which all are entitled to a basic benefit (paid at the same rate as job seeker's allowance: £60.50 a week). However, people who are judged (on a medically administered “work



capability” test) to be unable to work or with limited capacity for work will receive a higher level of benefit (“support allowance,” similar to incapacity benefit) with no conditions. Those who are deemed “sick but able to work” would receive an “employment support” component only if they participated in employability initiatives such as Pathways to Work.

The introduction of the two tiered employment support allowance means that for the first time in the UK conditionality applies to the receipt of sickness related benefits. However, it is in keeping with the reform of other UK benefits (such as unemployment benefit) and changes to sickness absence benefits elsewhere in Europe. Generally such reforms are sold as a way to reintroduce recipients to the labour market or to provide an incentive for people to look for and return to work—although there is no evidence of their effectiveness. However, the reforms also need to be understood in the context of the political debate about the relation between incapacity benefit, health, and employment.

Incapacity benefit has long been criticised as providing a means of avoiding work and as a mechanism whereby levels of unemployment are hidden. Despite evidence that medically certified sickness absence (including incapacity benefit) is actually a good indicator of health and mortality, political and media debates are dominated by the view that incapacity benefit is a disincentive to work and that people with

good health choose to fake sickness to receive it. The discourse around “fake” claimants (usually people with a diagnosis of a mental health problem) has popularised the view that some types of illness, and therefore some patients, are less deserving of state support than others. Such concerns are reflected in the employment support allowance's separation of health based claims into two distinct categories: people considered sick but able to work (undeserving poor) will receive lower levels of benefit unless they participate in compulsory employability programmes, whereas those considered to have a more severe illness or disability (deserving poor) will receive a higher rate of unconditional benefit.

Sickness related benefits are among the last in the UK welfare system to be reformed and until recently did not attract as much popular stigma as other benefits. This is also the case in other countries, where people who receive benefits because of ill health or disability have been viewed and treated as more “deserving” than those receiving other types of benefit. The reform of incapacity benefit is a move away from this and may signal a potentially disturbing political discourse about how some patients who are unemployed because of illness or disability are less deserving of unconditional public support than others.

It is unclear how all this will play out, but it seems likely that the deserving/undeserving dichotomy may well reinforce and magnify the existing stigma attached to claims that are based on mental illness and may therefore further increase health inequalities. Either way, it will have important implications for the health professionals involved, as the validity of professional medical certification is being questioned by the government, and healthcare workers will become increasingly involved in regulating the poor.

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REVIEWS OF THE WEEK

History on a knife edge

The new series looking at the brutal and dangerous history of surgery is instructive—and often amusing, finds **Harold Ellis**

Blood and Guts—A History of Surgery

BBC Four, 9 pm, Wednesdays

Rating: ★★☆☆½

The history of medicine is a fascinating subject, and undoubtedly it is the surgical aspects of this topic that appeal most to the lay television audience. The drama of the operating theatre, steely eyes over the white face mask, has lost none of its fascination in spite of countless programmes of both fact and fiction.

This latest contribution to the history of surgery, a series of five one hour programmes on BBC Four, is ambitious and interesting. It will intrigue the lay audience and, on the whole, its viewers in the health professions. It is presented throughout by the medical journalist Michael Mosley, who is medically qualified and who confesses that, as a student, he wanted to be a surgeon. He is cheerful and interesting and spares himself not at all in illustrating his material. He has a leech suck his blood, is hypnotised (he is an excellent subject), sniffs ether (nasty) and chloroform (pleasant), and gets drunk on

Michael Mosley has a leech suck his blood, is hypnotised (he is an excellent subject), sniffs ether (nasty) and chloroform (pleasant), and gets drunk on vodka

vodka. He submits himself to hypothermia in the men's outdoor swimming pool in Highgate in mid-winter, experiments with hypoxia on Hampstead Heath, has Botox injected into his face in Harley Street, and has his motor cortex stimulated in University College Hospital. He learns how to operate on a pig's heart and

how to perform a microvascular anastomosis, remaining happily informative throughout.

The first episode, "Bloody Beginning," deals with the four basic needs for effective surgery—an accurate knowledge of anatomy, control of bleeding, pain relief, and preven-

tion of infection. We see Andreas Vesalius, the young professor of anatomy at Padua, whose bible was the dissected human body and whose *De Humani Corpora Fabrica* (1543) was the basis of modern anatomical knowledge. Then on to Ambroise Paré and his reintroduction of ligation of blood vessels in 1564 to replace haemostasis by cauterisation. Pain relief over the centuries relied on opium and alcohol (or the two together—laudanum) until the introduction of ether by William Morton in Boston in 1846 and of chloroform the following year by James Young Simpson in Edinburgh.

Mosley then moves on to the dramatic and sad story of Ignaz Semmelweis and his work on puerperal infection in the maternity hospital in Vienna. He died in a mental hospital, probably of septicaemia, having failed to convince his colleagues that the hands of the obstetrician spread the contagion. By a sad coincidence, in the year of his death, 1865, Joseph Lister in Edinburgh treated his first compound fracture patient by antiseptic technique using carbolic acid. Antiseptic, and then aseptic, surgery enabled the rapid advances in modern, safe, technical surgery over the next couple of decades.

Mosley moves on to cardiac surgery in "Bleeding Heart," bringing to mind a quote from 1893 of Theodor Billroth: "Any surgeon who would attempt an operation on the heart should lose the respect of his colleagues." Four years later Ludwig Rehn saved the life of a young man by suturing a stab wound of his right ventricle. Mosley takes us through the story of the work on hyperthermia, the development of the heart-lung bypass, and cardiac transportation and ends with a visit to a patient in Paris trundling his artificial heart on a trolley while he awaits a suitable heart donor.

"Spare Parts" deals with transplant surgery, starting with teeth in the 18th century (rejected after a couple of months), then the pioneer work of Alexis Carrell, who solved the technical problems of organ transplantation in the early 20th century but was defeated by the biology of



Mosley: cheerful, and spares himself not at all

organ rejection. The Nobel prize winner Joseph Murray is interviewed, who performed the first identical twin transplantation, as is Roy Calne of Cambridge, who helped to develop the drugs used today to prevent organ rejection.

Later Mosley also investigates plastic surgery—especially facial reconstruction. He starts with paraffin injections to produce a perfect nose (disastrous) and then Botox for wrinkles, and goes on to the more serious problems of reconstruction of the faces of first world war soldiers by Harold Gillies and of burnt airmen in the second world war by Archibald McIndoe. We view the first successful partial face graft and consider the possibility of total facial replacement.

In "Into the Brain" we pass from a modern neurosurgical operation to remove an anomalous cerebral vessel in a girl with a severe focal epilepsy to the pioneer work of Harvey Cushing in Boston and the bizarre story of Walter Freeman, who performed thousands of leucotomies on patients with mental disorders.

This is a splendid series with much unique historical film footage. Of course, there are things to criticise. Paré, my personal hero, was not an "ignorant barber," even if he could not read Latin, but a skilled and experienced surgical teacher. And was it really necessary to go into a modern dissecting room to illustrate the importance of anatomy? My new students often faint at their first exposure to a corpse—was this done to titivate rather than educate? These minor points aside, this is an instructive and often amusing contribution to surgical history. Harold Ellis is emeritus professor of surgery, University of London

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Bela Schick's way
with words,
p 521



Clinical ethics comes of age

Daniel K Sokol is impressed by a collection of case studies that signals a new stage in the development of clinical ethics

For the past week I have enjoyed my bus journey to work. In the discomfort of my seat I pondered ethical dilemmas, like a chess fanatic relishing a strange position on the board. In the 28 chapters of *Complex Ethics Consultations* North American hospital ethicists share their most haunting cases. In "The Sound of Chains" Jeffrey Spike recounts the story of Angel, a comatose baby on a ventilator. The prognosis is bleak: an enduring coma or a permanent vegetative state. Angel was a shaken baby, and his mother, a suspect, asked to see him. The question posed to the ethicist over the phone: "Should the mother be allowed to visit her child?" The healthcare staff were divided over the issue. When the mother arrived at the hospital she wore an orange prison jumpsuit with heavy chains joining her wrists and ankles. She wants to hold the baby. Should this be permitted? As she gently rocks the baby in her arms, the heartbreaking options are laid out: withdraw the ventilator or place Angel in the next available nursing home. For Spike this case represents "the true meaning of tragedy."

In another chapter Denise Dudzinski presents 50 year old Cindy Johnson, who injured her wrist 10 years ago working on an assembly line. She had tried, with no success, various psychiatric and physical therapies to cure her complex regional pain syndrome, a neuropathic disorder that made any contact with the exposed skin of her left arm and wrist excruciating. Suffering from oedema, cellulitis, and joint contractures she now wants to amputate her arm, even if it might not relieve her pain. "I'm sick of being careful with it and telling everyone else to watch out. I can't play with my grandson for fear of bumping into him," she said. Uncertainty over Cindy's best interests remains to this day. While ethicists try to bring clarity to an ethical problem, Dudzinski reminds us that "striving for clarity does not mean striving for certainty." A good ethicist should identify morally relevant uncertainties.

The other chapters follow in a similar vein, each divided into case presentation, professional reflections, haunting aspects, outcome, and questions for discussion. However enthralling they may be, the volume is not about cases. It is about the hardships of doing clinical ethics and the people who perform ethics consultations. Each chapter is an invitation to enter the mind of the ethicist; thus D Micah Hester, caught in a disagreement over the appropriate goal of care for a severely anoxic baby,

candidly confesses in an excellent chapter: "I am haunted by the thought that I did not do enough, groped around too much, did not speak up, asked the wrong questions, and failed to push for further and deeper clarification."

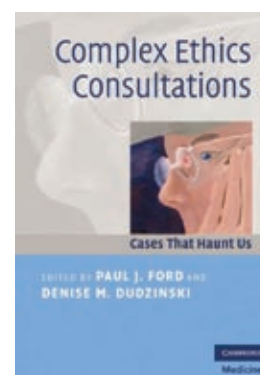
Hester notes with regret that he did not talk to the parents, who, contrary to the healthcare team, wanted aggressive treatment to continue. He relied instead on the accounts of hospital staff. The lesson is clear: talk to the patients, relatives, and other stakeholders when making an ethical evaluation; insights may be gleaned from the careful listening of different narratives. In my experience, clinical ethics committees, the dominant model in the United Kingdom, do not usually follow this advice.

Another key lesson is that ethics consultations, like all medical interventions, can harm as well as benefit. Ethicists make errors, and these can have dire consequences. Joseph DeMarco and Paul Ford discuss the case of Mr Carl, a 60 year old man who had open heart surgery three days before the ethics consultation. On continuous ventilatory support since the operation, he is, his wife believes, in great pain. She wants to withdraw the ventilator, claiming that her husband would not want to live in such a state. The surgeon disagrees: it's only been three days; the patient needs time to recover. After several hours of heated deliberation by Mrs Carl, the healthcare staff, and the ethics team, the nurse removed the ventilator. "It was difficult to sleep that night," write the authors. "We could have been wrong in this case. If we were, a person would have died without the chance he should have had."

It takes courage and humility to speak so openly about the doubts, weaknesses, and errors in our work, whatever the profession. This volume uncovers the moral richness and complexity of clinical practice, but it also raises important questions about the value, roles, methods, and training of clinical ethicists—signs of a budding profession. From the 19th century, especially in Britain, emerging specialties have often been faced with initial distrust or scepticism from more established disciplines. Clinical ethics is no exception. This collection signals a new stage in the development of clinical ethics, out of childhood and into an adolescence that is occasionally troubled and confused but also full of hope and promise.

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Complex Ethics Consultations: Cases that Haunt Us

Eds P Ford, D Dudzinski

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It takes courage and humility to speak so openly about the doubts, weaknesses, and errors in our work, whatever the profession

Team MB

FROM THE
FRONTLINE
Des Spence



The sports were often boring, but we sat blurry eyed on the couch, cheering on our athletes. We were glad that there were no velodromes in Africa, we praised John Major, we embraced Scots as British, we felt a sense of guilty pride as the national anthem resounded at full volume, and we smiled at the Australians. Sport is like art, with a quality to enrich lives that transcends religion, sex, and class—this in an economic climate when half the population may be reduced to eating spam sandwiches. There is something deeply admirable and levelling about sportsmen and women: it is the tangible nature of their achievement, the spectacle, the commitment, the passion, and the marriage of the individual and team.

It is odd then that competitive sport is so marginalised in our educational system and is seen as eroding children’s self esteem. So instead we suffer the tedium of non-competitive sports days and futile games of football where no one counts the goals. This non-competitive zeal is everywhere. The once mighty A level examination now has a 97% pass rate, and the medical training application service (MTAS) debacle was partly sparked by application forms that allowed nothing to be written on them. This is all in the name of that social monster “fairness,” which is levelling

traditional social structures—but the rubble is just as uneven and unequal.

Competition is the invisible force that drives us all on, and to suggest otherwise is dishonest. And contrary to the current dogma, competition is the very engine of self regard. Esteem ebbs and flows though our lives; it is not a gift or inalienable human right but instead is earned through perseverance. Winning is important, but losing the more so, for it is the phoenix of renewal. Sport has always been a proxy for society and used throughout history to maintain values. Regrettably, this team mentality has been replaced with a gang mentality.

Doctors forget that medicine is a team sport too, where the needs of the individual are secondary to the needs of the group and where respect, loyalty, trust, commitment, belief, and passion define us as doctors. These are the historical core elements of any successful progressive general practice or innovative hospital firm. So Team GB’s legacy must be that we do not shy away from competitiveness but rather recapture its energy. Medicine should get off the comfortable professional couch and strive harder in the race of life.

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Sunrise, sunset

THE BEST
MEDICINE
Liam Farrell



It was late, and we were closing up, when the surgery bell rang. We peered out; no one was there. Then we looked down.

“It’s a baby,” somebody said.
“I can see it’s a baby,” I replied,
“But what’s it doing here?”

Common sense would have suggested that we contact social services, but we’d read the books, we’d seen the movie, we knew what was expected of us.

“We’ll just have to raise it ourselves,” we agreed; some conventions must be observed.

We set up a cot in the corner of the surgery and engaged a wet nurse (breast is best). It wasn’t easy: the night feeds, the temper tantrums, and there was also the baby to look after. But those were good times; we’d get strange looks when we took him out in the pram, but we were happy, if a bit weird.

He had a contented, normal

upbringing in every way, except for some quirks. Birthday parties, for example. I’d point out all the sharp and potentially lethal objects in the surgery, then we’d play a game of blind man’s buff, the winner being the one with the lacerations least likely to lead to long term scarring and disfigurement—a bit of brain freezingly unforgettable terror and excruciating pain is an essential part of the magic of childhood. Balloon figures in the shape of the fallopian tubes were another perennial favourite, not just fun but educational as well, although when he was in pre-school he did sometimes look a bit confused.

The teens were typically difficult: get away from those people, his hormones were telling him, they know nothing. He was lost and lonely, like the sad heart of Ruth, sick for home amid the

alien corn, and he needed kid glove treatment and assurance that the changes to his body and the strange new feelings were quite natural and all part of maturing into an unemployable adult.

And then, one day, he said something that made me realise he was ready for the real world, ready to flap his wings and fly; if you love something, let it go, I thought, it’ll come back to you if it needs a prescription. Overnight, it seemed, my baby had metamorphosed into a young man.

“I’ve an awful pain in my back,” he said, “Can I have a sick note?”

Sad yet proud, I wiped a little tear from my eye; they grow up so quickly, don’t they?

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The wisdom of Falstaff

The government, I have read in various newspapers, wants to try bribing us into shape. Those of us who are fat will be given cash incentives to lose weight, apparently. Of course, I can quite see the logic of this: it will save the country money in the end. But perhaps an even better idea would be televised humiliation sessions for those who failed to lose weight, in front of a paying, and possibly even a baying, audience, complete with punishment for the worst offenders, as voted by the viewers. Not only would this save money in the long term, it would positively raise money in the short term. The television rights could be substantial.

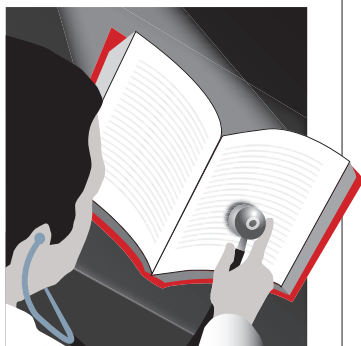
Like every doctor I am against obesity, smoking, and animal fats and in favour of lentils and exercise. But once, when investigating the way people actually lived, I attended a bingo hall, which I had never done before, and saw a large number of overweight elderly people having a lovely time, smoking, drinking beer, and eating chips. It was the very antithesis of doctors' orders, and it lifted my heart to see so many people disobey us utterly.

I bet they all lied to us as well, telling us how, despite their very best efforts, the weight just wouldn't come off.

I couldn't help thinking of Falstaff. The old man—that "whoreson obscene greasy tallow-catch"—is wholly reprehensible of course, and yet one wouldn't have him other than as he is. Excellent as uprightness and good sense are, a world in which everyone without exception was upright and sensible would be more or less intolerable.

In the bingo hall I remembered how Falstaff, playing Prince Hal to Prince

BETWEEN
THE LINES
Theodore Dalrymple



A world deprived of foolishness, of gaiety for its own sake, of non-conformity to the dictates of good sense, such as is dreamed of by puritans of all stripes, whether religious or medical, would be dreary indeed

Hal's King Henry in an imaginary rehearsal of Prince Hal's interview with his disapproving father, utters this encomium to himself:

"That he is old, the more the pity, his white hairs do witness it, but that he is, saving your reverence, a whoremaster, that I utterly deny. If sack and sugar be a fault, God help the wicked! If to be old and merry be a sin, then many an old host I know is damned. If to be fat be to be hated, then Pharaoh's lean kine are to be loved. No, my good lord! Banish Peto, banish Bardolph, banish Poins—but for sweet

Jack Falstaff, kind Jack Falstaff, true Jack Falstaff, valiant Jack Falstaff—and therefore more valiant, being as he is old Jack Falstaff—banish not him thy Harry's company, banish not him thy Harry's company. Banish plump Jack, and banish all the world."

And the strange thing is that, when he says it, we know that it is true: that a world deprived of foolishness, of gaiety for its own sake, of non-conformity to the dictates of good sense, such as is dreamed of by puritans of all stripes, whether religious or medical, would be dreary indeed.

Not that Falstaff is beyond redemption. When he claims, preposterously, to have killed Harry Hotspur himself in the battle at Shrewsbury, and hopes for an earldom or a duchy as a reward, he says: "If I do grow great, I'll grow less, for I'll purge, and leave sack, and live cleanly as a nobleman should do."

I think he would have been a good candidate for the government's bribery treatment.

Theodore Dalrymple is a writer and retired doctor
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MEDICAL CLASSICS

Aphorisms and Facetiae of Bela Schick

By I J Wolf First published 1965

"Meetings are for meeting people—the scientific sessions are of secondary importance," declared the professor to his retinue, commenting on an issue rekindled in recent years by the advent of video teleconferencing. On another occasion he wistfully reflected: "After 20 years one is no longer quoted in the medical literature. Every 20 years one sees a republication of the same ideas."

The professor, Bela Schick, was born in Hungary, studied in Austria, and from 1923 to 1942 was director of paediatrics at Mount Sinai Hospital in New York. At his retirement he suggested that every chief should have a dog and leave it in the department where he had served; for like Ulysses returning to Ithaca after his long absence he will find that only his dog will recognise him. But in scientific circles Dr Schick is remembered for devising the test used to determine susceptibility to diphtheria. The Schick test (1911) consisted of injecting intradermally a small amount of toxin; redness and swelling of the skin around the injection site indicated a positive result.

Like many university professors of his time he had a tendency to develop an oracular style and cast precious pearls before his impressionable younger associates. He had, moreover, a compulsive younger associate who early in life had developed the habit of committing his various chiefs' utterances to paper. At Mount Sinai Hospital I J Wolf wrote down Dr Schick's sayings and later published them in a 50 page book. Many of the sayings are memorable and still relevant.

Be humble, be kind to your patients, and be sceptical, for your patients have the right to more than mere science. One of his favorite expressions was "tincture of time," for

Schick as depicted on a Jewish-American Hall of Fame silver medal, 1957

time was the physician's best remedy in treating or clarifying a difficult case. On ward rounds, when an x ray picture was nowhere to be found, he would say that "someone must have it in his private collection." Once he said that you could always make a theory but must keep open a window so as to throw it out if necessary. "Statistics could prove anything, even the truth." And "it takes 10 years for a good idea to become established—10 years for a wrong observation to be forgotten."

He did not like seeing babies placed in rows in the nursery "like bread on a baker's shelves," for "to expose a newborn to infection is criminal." On the subject of retirement from medical practice he suggested that it was very difficult to slow down, for the practice of medicine was like the heart's contraction, all or none. Commenting on a case where an inordinate number of tests had been ordered, he remarked, "He did not know a case could have so many possibilities of investigation." And when a subaltern was droning on and presenting a case in a monotonous and inaudible voice he turned around and said, "Please—louder and funnier."

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