BRIEF REPORT: Physician Discomfort and Variability with Disability Assessments

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BACKGROUND: Completing a disability assessment is a common physician task; yet, little formal training is available.

OBJECTIVE: To assess physician comfort with disability assessments, and evaluate their consistency.

DESIGN: We conducted 2 separate surveys. The "Comfort" survey asked physicians to rate their comfort (1=very uncomfortable to 10=very comfortable) with 12 potentially uncomfortable tasks, including disability assessment. The second survey described 2 different patients requesting disability assessment, 1 with acute and the other with chronic back pain; participants assigned each a level of disability.

PARTICIPANTS: Resident and staff physicians at an urban county hospital.

RESULTS: For 54 physicians returning "Comfort" surveys, disability assessment had the lowest average comfort rating (4.3, SD 1.9) compared with all other tasks (mean ratings ranged from 4.8 to 8.0). For the 73 physicians returning the "Disability Cases" survey, 88% found Case 1 qualified for limited employment, but varied on the types of limitations imposed. For Case 2, 39% assigned no disability, 39% limited employment, and 22% full disability.

CONCLUSIONS: Our pilot studies support the hypothesis that physicians are not comfortable with disability assessment, and their assessments can be highly variable. Physician discomfort and lack of training may contribute to variability in disability assessments.

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Aiding in the determination of patients' eligibility for disability benefits is an important physician task. In 2002, more than 1,682,500 applications were received for federal disability, with other public and private disability benefits adding many more.¹ Future projections show that disability applications will continue to grow in number and cost. Estimates project that U.S. government expenditures for disability benefits will grow from \$60 billion in 2000 to more than \$85 billion by 2010.²

Despite the frequency of disability assessment requests and the important role that physicians play in supporting these applications, little training is offered in most primary care medicine residencies. Definitions of disability vary between federal, local, and private programs, adding a further challenge to physician assessments.³ Previous works have referred to physicians feeling uncomfortable with their role in disability assessment.^{4,5} Because of the lack of information or training available to guide primary care physicians in the task of disability assessment, we hypothesized that many physi-

cians feel uncomfortable with this task, and vary in their assessment of disability.

METHODS

This report describes 2 separate pilot surveys, conducted about 1 year apart, at an urban county hospital where disability assessments are frequently performed. The surveyed hospital does not currently have in place any formal curriculum related to disability assessments.

Survey Instruments

The first 12-item survey, "Physician Comfort," compared the level of comfort for disability assessment with other potentially uncomfortable physician tasks. Physicians rated their level of comfort on a scale from 1 (very uncomfortable) to 10 (very comfortable) (see Appendix 1, online). Items included a broad spectrum of potentially uncomfortable tasks without any suggestion of our underlying research focus. Items included running a code, discussing end-of-life issues, assessing competence, teaching students, pelvic examination, prescribing narcotics, interacting with pharmaceutical representatives, legal documentation, presenting a case, discussing domestic abuse, and assessing for disability.

The second survey, "Disability Cases," included 2 case descriptions of female patients requesting disability: one was a 41-year-old with a recent injury and acute back pain and the other was a 56-year-old with a 10-year history of chronic back pain. Each case included a history and physical exam (see Appendix 2, online). Respondents chose an assessment from 4 options: 1) may return to work without restrictions (no disability), 2) limited employment with specific restrictions (temporary and/or permanent), 3) not able to work (complete disability) but may return to work in a specified time, and 4) not able to work (complete disability) and will reevaluate in a specified time. Assessment options were taken from a commonly used county disability assessment form.

Subjects

The first survey was distributed to a convenience sample of resident, fellow, and staff physicians attending a noon lecture. The second survey was mailed to all medicine residents ($n=54$) and staff physicians ($n=94$). Both survey studies were approved by the hospital Human Subjects Research Committee.

Analyses

For the "Comfort" survey, comparisons between physicians' ratings of the different tasks were made using the Wilcoxon signed-rank test. The t test was used to compare the mean

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ratings for the residents versus staff physicians for each task. Physicians' disability assessments were categorized as no, limited, and complete disability. The χ^2 statistic was used to compare resident and staff physicians' disability assessments.

RESULTS

Physician Comfort with 12 Common Tasks

Fifty-four physicians returned "Comfort" surveys (Table 1): 39 residents, 4 fellows, and 7 staff. Physicians reported the least comfort with disability assessments (mean rating 4.32, SD 1.87). The differences between the average ratings for comfort with disability assessments and each of the other tasks, except running a "code," were statistically significant ($P < .002$ for each). Notably, staff and fellows reported similar levels of comfort with disability assessments. For several other tasks (prescribing narcotics, assessing competency, teaching), fellows and staff reported greater comfort than residents.

Disability Assessments

Seventy-three "Disability Assessment" surveys were collected from 29 residents (54%) and 30 staff (32%); the remaining did not identify themselves. For Case 1, an otherwise healthy 41-year-old woman with an acute back injury, 3 (4.1%) physicians assessed the patient as having no disability, 64 (87.7%) assessed the patient as having limited disability, and 6 (8.2%) assessed the patient as having complete disability (Table 2). For Case 2, a 56-year-old woman with chronic pain and a history of depression and fibromyalgia, 28 (39%) physicians assessed the patient as having no disability, 28 (39%) as having limited disability, and 16 (22%) as having complete disability. For physicians who chose limited disability, the specific restrictions listed by the physicians varied. Lifting restrictions for Case 1 ranged from 5 to 40 lbs, and time restrictions ranged from a 1- to 6-week duration. Similar results were found in

Table 2. Disability Assessments Made for Patients Described as Having Acute and Chronic Low Back Pain

Disability assessment	N (%)		
	Residents	Staff and Fellows	All
Physicians*			
Case 1, acute back injury and pain†	27	30	73
No disability	2 (7%)	1 (3%)	3 (4%)
Limited disability	24 (89%)	27 (90%)	64 (88%)
Complete disability	1 (4%)	2 (7%)	6 (8%)
Case 2, chronic back pain†	26	28	72
No disability	13 (50%)	11 (39%)	28 (39%)
Limited disability	11 (42%)	6 (21%)	28 (39%)
Complete disability	2 (8%)	11 (39%)	16 (22%)

*The total number of physicians does not equal the number of residents, fellows, and staff completing each case as some physicians did not identify their level of training.

†Disability assessments were not statistically significantly different between residents versus staff and fellows for case 1 ($P > .1$), but were for case 2 ($P < .05$) based on the χ^2 statistic.

Case 2, with lifting restrictions ranging from 5 to 20 lbs and time restrictions ranging from a 2-week to 6-month duration.

Disability assessments for Case 1 did not differ by level of training: approximately 90% of physicians chose limited disability (Table 2). For Case 2, however, resident and staff physicians differed. Significantly more staff and fellows chose complete disability compared with residents (39% vs 8%, $P < .05$). We did not find any significant difference in the distribution of disability assessment by physician gender.

DISCUSSION

With the "Physician Comfort" survey, we attempted to assess anecdotal reports of physician discomfort with disability assessments. Our pilot study supports the idea that compared with other common potentially uncomfortable tasks, physicians are the least comfortable with disability assessments. It was striking that physicians at all levels of training found disability assessment the most uncomfortable task. This task may be inherently uncomfortable regardless of physician experience or skill. Carey and Hadler⁶ published a discussion of disability determination in which they suggest that physician discomfort may stem from the various and sometimes contradictory roles that a physician plays. These roles include being a source of information; advocate and counselor; and adjudicator and certifier. Carey and Hadler note "a doctor cannot act as an advocate for a patient's disability claim on 1 visit and as an adjudicator on the next visit without straining the therapeutic relationship."⁶ This type of conflict may contribute to the lack of comfort among our respondents.

We used 2 disability case scenarios to evaluate for variability among physician disability assessments. Our results show less variability among the disability assessments for Case 1, a patient with an acute back injury. Despite most physicians choosing limited disability, however, the types of limitations that physicians suggested varied in terms of weight restrictions and time duration. Physicians' responses to Case 2, describing a patient with more chronic symptoms, had much greater variation. Physicians were almost evenly divided in assessing that the patient had no, limited, and complete disability.

Table 1. Physician Comfort with 12 Common Tasks

Task*	Mean Score (SD)		
	Residents	Staff and Fellows	All Physicians
Disability assessment	4.2 (1.5)	5.1 (2.9)	4.3 (1.9)
Running a Code	5.0 (1.7)	5.6 (3.1)	4.9 (2.8)
Completing legal documents (e.g., insurance forms)	5.3 (2.1)	6.6 (2.0)	5.6 (2.2)
Interacting with pharmaceutical representative	5.5 (2.6)	6.4 (2.6)	5.8 (2.7)
Prescribing narcotics†	5.7 (1.5)	7.6 (2.0)	5.9 (1.9)
Competency†	6.2 (1.8)	7.3 (2.1)	6.3 (1.9)
Assessing domestic abuse	6.7 (1.5)	6.9 (2.0)	6.5 (1.9)
Placing a central line	7.1 (3.4)	6.4 (3.4)	6.6 (2.8)
Teaching medical students†	7.4 (1.6)	8.7 (1.6)	7.4 (2.0)
Presenting a case in front of a group	7.5 (2.2)	8.3 (2.2)	7.45 (2.1)
Pelvic examination	7.7 (2.6)	7.6 (2.6)	7.6 (1.9)
End-of-life discussion	8.1 (1.2)	8.8 (1.17)	8.0 (1.8)

*All tasks were rated on a scale of 1=least comfortable to 10=most comfortable. The mean comfort rating for disability assessment was significantly different for all other tasks except for running a code ($P < .002$ for each comparison using the t test).

†Staff physicians felt greater comfort with narcotics, competency evaluation, teaching, and completing legal documents compared with residents (all comparisons used the t test, $P < .05$).

Our results do not reveal the reasons for increased variability seen in Case 2. Several possibilities deserve consideration. The data provided in the case scenario might be inadequate for more complex patients, and the assessment form used offers little framework for guiding physician responses as a function of patient characteristics. We also speculate, however, that a physician's own context for patient assessments may be more greatly evoked by the more complex patient. For example, Internists may vary in their comfort with issues such as psychiatric comorbidities, fear of manipulation, or failure to detect malingering. These physician-specific characteristics might become more important decision determinants when the patient characteristics are complex or ambiguous.

Our pilot studies are limited in several ways. Our small sample is drawn entirely from 1 hospital and our response rates were low for the case scenarios. This may limit the generalizability of our results to other practitioners and sites. In addition, we could not compare physicians who responded to the surveys with those who did not respond. But it seems unlikely that physicians with less comfort and skill with disability assessment responded to our surveys out of proportion to physicians with more comfort and skill. Third, the "Disability Cases" survey used written case scenarios. Physicians' responses to case scenarios may not reflect their actual patient assessments. Recent studies by Peabody et al. have demonstrated that physicians' responses to clinical vignettes reasonably predict the care they deliver to standardized patients^{7,8} Finally, our survey used only 1 format for disability assessments based on a commonly used county form; other assessment forms and guidelines may yield different results.

In spite of the limitations in our pilot studies, our results suggest that physicians are uncomfortable with and vary in assessing disability, an important and frequent physician task. Further study with larger, more representative samples is warranted. Evaluation of the process of assessing disability,

physician training for disability assessments, and the structure of disability forms may clarify the underlying causes of physician discomfort and variability in assessing disability and identify ways to alleviate problems.

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Supplementary Material

The following supplementary material is available for this article online:

Appendix 1: Physician Comfort Survey.

Appendix 2: Physician Disability Assessment.