

Factors that influence doctors in the assessment of applicants for disability grant

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Abstract

Background: A disability grant is the financial assistance given by the government to South African citizens and bona fide refugees who have debility that results in inability to work. Doctors in state hospitals and clinics are tasked with the duty of assessing applicants for this grant. Ideally, the assessment is done by an institutional committee consisting of a doctor, physiotherapist, social worker, occupational therapist and specialised nurses. However, this is not always the case because of a shortage of personnel, particularly in rural areas. A lack of clear guidelines for the assessment process has led to confusion and differences in the outcomes. This poses major problems for the doctors, as well as the applicants, who often are dependent on the grant for survival. The aim of this study was to explore the factors that influence doctors in the assessment of applicants for a disability grant.

Methods: A qualitative study using free attitude interviews was conducted amongst doctors involved in the assessment process in Limpopo province. Content analysis was used to identify themes from the interviews.

Results: The assessment process was not entirely objective and was influenced by subjective factors. These included the mood of the doctors, emotions such as anger and sympathy, and feelings of desperation. Perceptions by the doctors regarding abuse of the system, abuse of the grant, the inappropriateness of the task, lack of clear guidelines and the usefulness of the committees were important in decision making. The doctors' personal life experiences were a major determinant of the outcome of the application.

Conclusion: The assessment of applicants for a disability grant is a subjective and emotional task. There is need for policy makers to appreciate the difficulties inherent in the current medicalised process. Demedicalisation of certain aspects of disability assessment and other social needs that doctors do not view as a purely clinical functions is necessary. In addition, there is a need for clear, uniform policy on and guidelines for the management of the grant, the role of the doctor has to be defined, healthcare practitioners must be trained in disability assessment, institutional committees should be established and intersectoral initiatives should be encouraged to address issues of poverty and dependence.

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Introduction

In South Africa, a disability grant is the financial assistance given by the government to citizens and bona fide refugees who have debility that results in inability to work. The grant was previously administered by the Department of Health and Welfare, but now falls under the Department of Social Services. Doctors in state hospitals and clinics are tasked with the duty of assessing applicants for this grant. Ideally, the assessment is done by an institutional committee consisting of a doctor, physiotherapist, social worker, occupational therapist and specialised nurses. This is not always the case, however, because of a shortage of personnel, particularly in rural areas. In my setting, the assessment committee usually consists of the doctor, a social worker and the physiotherapist. On some occasions only the doctor is available for the assessment of applicants for a disability grant.

Historically, there were seven different government systems operating within South Africa in the apartheid regime; the main national government functioned alongside the homelands. Each of these had its own health and welfare system that provided different guidelines regarding disability grant administration. Guidelines were not uniformly available in all provinces and those that were available recognised the doctor as the one who recommended or disapproved the grant application. Since the integration of the seven governments into one in 1998, the National Department of Health has attempted to unify the assessment guidelines in all provinces. Notably, the different series of guidelines emphasise objective assessment of the applicants and do not take into consideration other factors that may play a role in this process. This results in misunderstanding between applicants and healthcare personnel. In their small numbers, doctors, especially in the rural areas, have to deal with large numbers of disability grant applicants. This is a source of extreme stress for the already overworked doctors, and at times results in discrepancies, with devastating consequences. The media have reported cases of suicide by applicants who fail to get the grant.

With the high unemployment levels in most parts of South Africa, a disability grant has become an alternative source of income. In my observation, the process of obtaining a disability grant is marked by deep emotion and, at times, manipulation, dishonesty and fraud. These are not taken into account by the objective evaluation tools, but play an important role in decision making during the evaluation.

I conducted this study to explore and gain understanding of the factors that influence doctors in the assessment of applicants for disability grant.

Method

A qualitative study was conducted in 2001. Five doctors working in public hospitals in the Northern Province (Limpopo province) and actively involved in disability assessment for at least two years were purposefully selected for the study. A free attitude interview was conducted in English with each participant. The exploratory question posed was: "How do your beliefs, feelings and other factors influence your assessment of applicants for disability grant?" Facilitation, reflective summaries and clarifications were used to exhaust information from the participants. Data were captured on audio and video recorders, and verbatim transcription of the data was done. Content analysis with identification of themes was done by the cut and paste method.

Written consent was obtained from the participants and the hospital managers. Ethical approval for conducting the study was obtained

from the Research Ethics and Publication Committee of the Medical University of Southern Africa (MEDUNSA).

Results

Themes emerging from the interviews are summarised in the two tables below.

Table I: Factors that positively influenced the doctors' assessment of applicants for disability grant.

Number	Theme
1	Disability assessment was a source of satisfaction and fulfilment, especially when assisting truly deserving persons
2	The institutional disability assessment committee was a dynamic forum promoting teamwork and shared responsibility
3	Personal life experiences of the doctors influenced the decisions they made
4	Stigma associated with some of the conditions positively influenced the doctors in awarding grants

Table II: Factors that negatively influenced the doctors' assessment of applicants for disability grant

Number	Theme
1	The lack of clear and comprehensive guidelines was a source of frustration
2	There was abuse of the disability management system by applicants
3	The process of assessment was influenced by emotions
4	The mood of the doctor was an important factor in the evaluation
5	The assessment of applicants was subjective
6	The perceptions of communities about disability and the grant resulted in doctors having a negative attitude towards and disapproval of the applications
7	Some doctors felt that the disability grant propagated unhealthy social habits
8	The disability grant benefited other people than the patient
9	Doctors perceived the evaluation of applicants as stressful and inappropriate duty
10	The doctors lacked motivation for this task and did not view disability assessment as a priority

The lack of clear and comprehensive guidelines was a source of frustration that interfered with the evaluation process and outcome. This was a source of disparity, as personal judgment came into play: "The guideline doesn't address the whole range of disabilities"; "You assess according to your judgment and sometimes there is no system to quantify the disability". This lack of clear guidelines at times led to desperation in the doctor. "What can I do? The system is full of holes."

The disability management system was being abused by communities and doctors were unwilling to be part of this abuse. "I feel the system has been abused and I am uncomfortable with this." "People are fleeing the system."

The process of assessment was influenced by emotions. Sympathy and sorrow towards the applicant resulted in an assessment leading to the applicant qualifying for the grant: "So, if I feel sorry for her then I will give disability grant"; "I feel obliged to give disability grant especially if I am made to feel sorry for the patient's social status". On the other hand, anger resulted in disapproval of the grant: "When you are annoyed, you assess and find that the patient does not qualify for disability grant"; "The most annoying thing is that everyone comes and many don't qualify for the grant. You automatically feel switched off. You don't listen properly".

The mood of the doctor was an important factor in the evaluation. Bad mood resulted in loss of objectivity: "Quantifying depends on your mood"; "At other times it may change your mood causing bad mood and you become emotional with patients"; "If my first impression is that this guy is joking, then immediately I write in the form that he doesn't qualify"; "...you can clear the queue if you are in a bad mood".

The assessment of applicants was noted to be subjective. This negated the view that the disability can be objectively measured and quantified: "There is always some subjective and you can't get rid of it completely"; "We deal with people and you can't do away with subjectivity".

The personal life experiences of the doctors influenced the decisions they made. The situation of the applicant was often compared with events experienced by the doctor: "I have been biased for a long time. Because my mother who has arthritis works, why can't they?"

Stigma associated with some of the conditions positively influenced the doctors in awarding grants. Doctors were sympathetic to stigmatised applicants, particularly those with mental illness or epilepsy: "The stigma is so thick (referring to mental illness). So that puts the person in a difficult situation and that person is entitled to disability grant"; "But if that person has an epileptic fit while he is at work, then there are very few people who can keep that person employed".

The perceptions of communities about disability and the grant resulted in doctors having a negative attitude towards and disapproval of the applications. Communities that took the grant as a right or as means of earning a living were the main culprits: "All the people without jobs or who feel weak think they deserve it. You cannot solve social problems with a disability grant". The feelings regarding dependency on disability grant by the applicants was a source of irritation for the doctors, resulting in disapproval of the application: "I would go on railing about the system and how people, I would say, are shackled in some kind of dependency"; "He sees that if he does not get the grant he is not going to live".

Some doctors felt that the disability grant propagated unhealthy social habits. There was a perception by some doctors that the money was used for purposes that propagated disease and debility. They viewed the disability grant as a motivation for applicants to maintain the severity of their disease, making efforts at rehabilitation fruitless: "Some people who are unable to function because of bad habits, like the alcoholics, they use the money to worsen themselves"; "There is no way for them to be reintroduced into normal life because they just believe in disability grant".

The disability grant benefited people other than the patient. This perception was the source of disapproval of the application by some of the doctors: "Mentally ill patients who are given the grant do not benefit from it. It benefits other able members of the family."

The doctors perceived the evaluation of applicants as stressful and inappropriate duty: "It causes stress sometimes because you think you are being dishonest"; "It would be wise if the doctor who sees the patient does the assessment right away".

The function of assessment was intimidating to the doctors, as they were blamed by the applicants and government officials for deficits in the system: "I am just doing my job and I get blamed for it"; "Doctors should not be made to look like the bad guys". The feeling by the doctors of being victimised often results in disapproval of the application: "There is a lot of victimization and the patient gets very annoyed."

Some doctors lacked motivation for this task and did not view disability assessment as a priority. They did not give the assessment of applicants for disability grant adequate attention. This resulted in applicants either not being assessed at all or being inappropriately assessed, resulting in them not qualifying for a disability grant: "There is no motivation behind that"; "We would like to optimise our work by seeing those patients that need us. I mean it was making more sense to go and treat patients in OPD than coming here to explain to people who deserves and doesn't deserve disability grant".

The institutional disability assessment committee was appreciated as a dynamic forum promoting teamwork and shared responsibility. The presence of such committees was appreciated by the doctors: "This committee sort of took the burden off me as a doctor"; "I don't have to feel that I am responsible for giving or not giving"; "Sometimes there is resistance, counter-suggestions and alternatives and the eventual decision is somewhat different from where you started".

Despite these challenges, there were occasions that the process was a source of satisfaction and fulfilment, especially when assisting truly deserving persons: "It is very nice treating this patient because you know that this little disability grant can be used to take him over"; "You can see that the limbs are gone or she does not see or hear. It is easy for me".

Discussion

This study demonstrated the complexity of the process used to assess applicants for disability grant. Its major finding was that the decision-making process was not only objective, but was influenced by many subjective factors that are usually not taken into consideration. These included emotions, personal life experiences, perception regarding stigma, anger, feelings of intimidation, stress and lack of motivation. The influence of the doctor's subjective feelings found in this study has real value and needs to be acknowledged. This is similar to findings by Baron from a study on disability assessment, in which he expressed the subjective influence as follows: "It is impossible not to feel sympathy for applicants who are obviously in dire financial needs ... It is easier to feel that a meek supplicant patient deserves a grant rather than a loud and aggressive one."¹ The conflicts arising from these subjective influences are mainly due to their diffuse nature and lack of clear boundaries. The importance of subjectivity is encapsulated in the principles of family medicine, which indicate that the physician should be interested and respect the subjectivity of a patient's life.² The manner in which a patient perceives and presents the problem is subjective. Similarly, the response by the doctor has a strong subjective component. In essence, a compromise on subjectivity needs to be reached. Being conscious of one's feelings could assist the doctor in accommodating the patient's reasoning.

This study showed the key role played by emotions in the assessment process. The discomfort caused by negative emotions such as distaste, impatience, annoyance, stress, bad mood and hostility often resulted in negative outcomes. Similar emotional dynamics in the doctor-patient interaction have been described by Ellis, who showed the negative effects of autogenic feelings such as anxiety, anger, irritation, sexual arousal, impatience, dislike and hatred on the doctor-patient relationship.³ According to Klein et al., certain medical conditions, particularly those that have little likelihood of cure, evoke negative responses from the doctor.⁴ In this study, social issues fronted as medical conditions were found to have similar influence. This was particularly so if the issues violated the doctor's personal norms, even though they had little or no bearing on the patient's health. Disapproval of an application on the basis of emotions could be construed as

discriminatory and could have deleterious effects on both the patient and the doctor.

The lack of good guidelines was seen as a major shortcoming of the entire process. A similar study done in KwaZulu-Natal identified a lack of good guidelines as a major issue.⁵ Baron, in his study on the winding process of application for disability grants, also described the difficulties caused by lack of clear guidelines.¹ Two government policy documents, the Integrated National Disability Strategy and the Health and Welfare document on the management of disability grants, also acknowledge the problems resulting from a lack of guidelines.^{6,7} It is apparent that this is a national issue that requires urgent attention. In developing guidelines there is need for intense consultation, particularly with the users. Lack of consultation may result in the users either not understanding the guidelines or not using them appropriately. This has been echoed by Calkins et al., who noted failure of the intended purpose of clinical guidelines in the United States of America due to lack of consultation.⁸

This study also found that some doctors viewed the assessment of disability as undesirable work. Similar sentiments have been expressed in studies by Mhlabi and Dodd, who found that assessment for disability was an undesirable and thankless task.^{5,9} This resulted in low prioritisation of this activity. The difficulties related to this activity are closely related to the high levels of dependence and medicalisation of social problems. Such difficulties are not confined to developing countries, but also occur in the developed world.¹⁰ Disability is largely a legal and social problem that needs a solution based on social principles. It is the responsibility of society to provide for the disabled. This study illustrates the ills of taking away the responsibilities of the society and allocating them to doctors by medicalising them. Such are the disadvantages of medicalisation described by Illich.¹¹ The diffuse and subjective nature of social problems is incompatible with conventional medical thinking. There is a need for an interdisciplinary approach in the holistic management of patients requiring a disability grant, as disability is a condition that stretches beyond medical limits. This interdisciplinary approach should include the medical fraternity, the social services specialists, psychological service providers, the economists, industrialists, the spiritual leaders and educationists. It is only through an all-inclusive holistic approach that the psychosocial problems will be addressed, and not through piecemeal efforts like the provision of disability grants.

The important role of the disability assessment committees was highlighted in this study. The committees are forums that allow for sharing of the burden, sharing of responsibility, protection of members from intimidation, legitimising the decision and suppression of personal feelings. Current guidelines on the composition of the assessment committee recommend the following membership: doctor, social worker, physiotherapist, occupational therapist, community-based rehabilitation worker, mental health-trained personnel and a community member (preferably a disabled individual). This ideal composition is impossible in many circumstances, however, due to a shortage of healthcare professionals. This is particularly a major problem in the rural areas, where there is critical shortage of doctors, physiotherapists and occupational therapists. The Health Survey conducted by the Health Systems Trust found that rural provinces such as Limpopo, Eastern Cape and North West have the lowest numbers of these professionals.¹² Migration to and opting for better opportunities in the urban areas account for some of the disparities in the distribution of health professionals. The negative influences of conducting the assessment of applicants without such committees have been highlighted by this study. They affect both the applicants and the health professional. It therefore is critical that disability assessment should

not be done by individual doctors, but within the confines of such committees.

The study also found that a lack of skills in the assessment and management of disability was a major deterrent to efficient provision of this service. Some doctors felt that they were inadequately trained for this role. This can be traced to medical training curricula that use a medical model rather than a biopsychosocial one, and also to the lack of structured training in psychosocial aspects of patient care for doctors in practice. The training of doctors typically lacks rehabilitation aspects, as this is left in the domain of the allied health professionals, although this is gradually changing with the inclusion of these aspects in the family medicine training of both undergraduates and family physicians. However, this training will not fully address the lack of uniformity and congruence in the functioning of the different health professionals involved in the assessment and care of patients with psychosocial problems. Health professionals train in parallel lines and there currently is little or no opportunity to train together. There is need for synchronised training to enhance the functioning of multidisciplinary teams.

The limitations of this study include the fact that it was confined to one region of the Northern Province (Limpopo province). It is possible that other areas in the country have different experiences that could be interpreted differently. Although the number of doctors involved was small, critical issues relating to this important process were identified.

Conclusion

This study raised a diversity of critical issues that are important for increasing the efficiency of the assessment of applicants for disability grants. It contributes to the call for understanding of the important role of subjectivity and the universal call for policy makers to appreciate the difficulties inherent in the current medicalised process. It highlights the need for demedicalisation of certain aspects of disability assessment, and for other social needs, as doctors do not view these as purely clinical functions for which they are trained. In addition, there is a need to have clear, uniform policy on and guidelines for the management of the grant, to define the role of the doctor, to train healthcare practitioners in disability assessment, to establish institutional committees and to encourage intersectoral initiatives to address issues of poverty and dependence. 🙏

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