LETTERS TO THE EDITOR

Occupational health physicians and tribunals

Dear Sir,

Kloss makes a number of key observations about the role of occupational health (OH) practitioners in relation to tribunal cases [1]. She states the importance of tribunals understanding the expertise of those in OH, but then describes a doctor with an Associate of the Faculty of Occupational Medicine as a ‘specialist’. An understandable error, but it does emphasize the difficulties non-medical tribunal chairmen and members have in understanding not just what title or qualification a doctor may have but what this actually means in practice. In the UK, only those with MFOM or FFOM (Members and Fellows of the Faculty of Occupational Medicine) are entitled to use the term ‘specialist’ and are included on the specialist register of the GMC.

Similar errors are often made about ‘specialist reports’. Often the ‘specialist report’ has in fact been prepared by a trainee, particularly in psychiatry, and although a consultant (specialist) may have checked the report, they may not have seen the patient. The trainee may be on a general practitioner (GP) training scheme, and may have only just started a 6-month rotation in that specialty. The report must be considered with this in mind.

Kloss also acknowledges that as an expert witness, the OH professional must not be ‘partisan’, suggesting that they might otherwise be so. Ethically, we must always provide balanced, objective reports [2]. This is the key difference between occupational physicians and treating clinicians who are generally expected to be the patient advocate. It is perhaps this that tribunal chairmen need to appreciate. It is not uncommon for specialists and GPs to provide advice that is neither evidence-based nor factually correct just because they have been asked to write this in a report to the employer. The government itself has acknowledged that statements by treating clinicians on a Med 3 (sick note) often just repeat the view of the patient without any attempt at objective assessment [3]. Tribunals should always view reports from treating clinicians with a critical eye.

Kloss also states that only around a third of tribunal cases actually come to trial. For disability cases, the figure is ~9% [4]. In those cases that actually do come to trial, tribunals do occasionally take a robust view of clinical ‘evidence’ where this is not clearly objective and evidence based [5]. What of the 91% of cases rejected, settled or withdrawn? How many are settled or withdrawn on the basis of incorrect ‘evidence’ or inappropriate advice? Tribunal chairmen take a common sense, proactive approach to dealing with cases that may include advising parties to seek appropriate advice and resolve issues without the need for a hearing. An understanding of the role impartial OH advice can play in this process is clearly important for all tribunal chairmen. Anecdote suggests that OH specialists are frequently asked for advice about cases going to tribunals but these are invariably settled before the hearing [6], so tribunal chairmen and members are less likely to come across specialist OH advice. It is often said about preventive medicine that those doing the best job are least noticed.

While we do need a good understanding of the tribunal process (and the editorial by Kloss is a useful introduction), other tribunal chairmen need a good understanding of OH. How is this to be achieved? Perhaps, our new OH Tsar could help.

Anthony Williams
Consultant Occupational Physician, Working Fit Ltd,
Dover, Kent, UK
e-mail: tonywilliams@workingfit.com

References

6. Association of Local Authority Medical Advisers Internet Discussion Forum. www.alama.org.uk

© The Author 2007. Published by Oxford University Press on behalf of the Society of Occupational Medicine. All rights reserved. For Permissions, please email: journals.permissions@oxfordjournals.org