Bellak, 19r

CI 2683 2004

## DECISION OF THE SOCIAL SECURITY COMMISSIONER

1 I allow the appeal. The decision of the tribunal is set aside. The appeal is to be reheard in accordance with the directions in this decision.

2 The claimant and appellant (Mr J) is appealing against the decision of the Sunderland appeal tribunal on 03 06 2004 under register number U 44 236 2004 03550.

3 DIRECTIONS FOR REHEARING

A The appeal is to be reheard at an oral hearing.
B The tribunal is to be differently constituted to any previous tribunal involved in this appeal.
C If either party wish a further medical examination of the appellant before the rehearing or wish to submit any further evidence to the tribunal, then they must notify the tribunal of this within one month of issue of this decision.

These directions are subject to any subsequent direction by a district chairman.

REASONS FOR THIS DECISION

4 Mr J claimed that his entitlement to industrial injuries disablement benefit be adjusted for prescribed disease (PD) D12, chronic bronchitis and/or emphysema, on 04 08 2003. He claimed that the date of onset was 17 01 1992. He worked as a miner for many years and has separately been accepted as suffering as a result of his work from both PD A11, vibration white finger, and PD D1, pneumoconiosis. He is therefore already receiving industrial injuries disablement benefit. This claim was rejected after a medical adviser, Dr Denton, advised after a medical examination of Mr J that he did not meet the criteria for that disease.

5 Mr J's appeal against the refusal went to an oral hearing by an appeal tribunal. The medical member conducted a hearing test. The tribunal found as fact as a result of that test that Mr J's did not meet the criteria for the disease. It dismissed the appeal.

*Was PD D12 present?*

6 PD D12 has one, at first sight, of the most technical definitions of prescribed diseases in Schedule 1 to the Social Security (Industrial Injuries)(Prescribed Diseases) Regulations 1985. It requires evidence of the forced expiratory volume from the lungs in one second (FEV1) by the claimant from the position of maximum inspiration with the claimant using maximum effort. The disease is prescribed only if the evidence suggests that FEV1 is at least 1 litre below an appropriate mean value of expiration calculated by a defined formula. In practice, FEV1 is measured by special

testing equipment in a process referred to as spirometry. The equipment is supplied with the relevant information to calculate and apply the appropriate mean value of FEV1 to the actual values of FEV1 of the individual being tested.

7 The tribunal applied the test. The test reading at the tribunal hearing showed a drop of 0.93 litres. The tribunal made a formal finding to that effect, and concluded that Mr J did not meet the statutory criteria.

*Grounds of appeal*

8 The record of proceedings of the tribunal shows that Mr J's representative cited CI 126 2002 to the tribunal and made a legal submission on the basis of that decision. His concern was about the effect on the tests of any medication taken by Mr J. The case is not mentioned in the tribunal's statement of reasons.

9 In CI 126 2002, Commissioner Angus considered a claim for PD D12 to be determined by a previous, different test to that which applies in this case. The difference in definition is not material here. The Commissioner made clear that the relevant spirometry test is that taken at the time of the original decision. This is because of the effect of the rule against "down to the date" decisions in sections 8 and 12 of the Social Security Act 1998. Both that case and this suggest that the previous tribunal practice of relying on the results of a test conducted by the tribunal was not changed to reflect the change in the Act. Under current legislation, it is the test conducted by a medical adviser, or the other evidence submitted by the adviser to the Secretary of State for the original decision, which is the primary evidence on which the decision is based. A later test applied by a tribunal is evidence that may support or contradict that contemporary evidence, but is no more than that. The tribunal in this case was required to decide the matter at the original date of decision. That was in October 2003. The tribunal made no findings of fact about the test applied at that time. It made no comment about Dr. Denton's test. I must therefore set aside the tribunal decision.

10 The representative did not cite CI 126 2002 for that reason. He raised the issue of the measurement of Mr J's FEV1 being distorted by medications taken by him near the time of the test. The Commissioner sets out in that decision a note of expert evidence about PD D12 submitted by Dr Peter Wright of the DWP Corporate Medical Group. One of the issues in that case was whether the spirometry results had been considered properly, taking into account in particular any medication taken by the claimant in that case. The Commissioner stated the position in law as follows:

> "In assessing the evidential value of the subsequent spirometry it would have been necessary to take into account whether or not the claimant's lung function might have been enhanced by medication. In assessing disablement it is legitimate to base the assessment on what the claimant can do when he has taken medication but for the purposes of diagnosis it is the unassisted function which is relevant."

The Commissioner reached that view after an oral hearing and after considering the detailed medical submission from the Secretary of State's own expert. I respectfully follow CI 126 2002. The tribunal did not expressly consider the submissions on CI 126 2002. The decision of the tribunal must be set aside for that reason also.

*How is Mr J's claim to be decided?*

11 When granting permission to appeal, I asked for medical advice from the secretary of state's representative on the significance of the use of the medicines said to have been taken by Mr J. In making his submission in support, the secretary of state's representative produced advice from Dr. Peter Wright. The representative relied on that advice to suggest that I should take the decision that the tribunal should have taken, and dismiss the appeal by reference to the original spirometry test.

12 Mr J's representative took exception to that course of events. With the help of the National Union of Mineworkers, he obtained an opinion from another expert. There was some delay in obtaining his advice but when it came it directly challenged the medical advice in the papers from the Secretary of State. That disagreement caused me concern. I invited the parties to suggest a way of resolving the conflict, including whether there could be an agreed expert view on the point. I have also considered, but after hearing from the parties rejected, appointing my own medical expert to advise me further. I agree with Mr J's representative on this point. I am unlikely to obtain anything other than another opinion about the opinions already expressed. For a similar reason, neither the parties nor I saw point in holding an oral hearing to clarify the evidence or discuss these points. I also considered whether there would be any value in having further tests of Mr J. But I do not consider that this would be fair on Mr J at this stage. The matter must be decided on the evidence now available.

*The evidence of the original spirometry test*

13 The test undertaken by Dr Denton is recorded in the papers by two documents. The first is a photocopy of an unsigned printout of the spirometry equipment reading at the time of the test by him. The second is a summary of that information signed by Dr Denton on form BI181C. There is nothing on either to indicate whether the test was taken with or without any possible effects from medication. I asked both parties to provide me with any further information or evidence about that test. Neither could assist. In his note to the Commissioner in CI 126 2002, Dr Wright comments on the need to look at the direct behaviour of someone being tested, and at the shape of the expiratory graph, in ensuring that the test is conducted properly. There is no evidence that any consideration was given to either of these matters by Dr Denton at the time of the original test. Nor is there any note about any medication being taken by Mr J. It is therefore not possible to establish from direct contemporary evidence whether or not the test conducted by Dr Denton was one where there might have been an effect caused by medicines, and therefore whether the test complied with the requirements of CI 126 2002.

*Pre-test guidance to a claimant*

14 As Mr J's representative argued, the position might be assisted by pre-test guidance to a claimant of which the testing doctor is aware. I have been shown recent guidance issued to those attending an examination for industrial injuries disablement benefit claims. It is issued by Medical Services on behalf of the DWP. That is now, I understand, run by Atos Origin. It is not specific to lung function or similar tests. It explains why the tests are held. Under the head "What do I need with me at my medical examination" it asks for "Tablets or other medication, such as inhalers" and "Any medical aids, such as walking aids, hearing aids, glasses and contact lenses". It gives no guidance about taking, or not taking, any medication before an examination. It does not help form a view about any possible inaccuracy in the test carried out by Dr Denton caused by medication.

15 I was also shown the much fuller "Information Sheet for Spirometry Lung Function Assessment" sheets given by Atos Origin to those attending Miners' Assessment Centres. This tells the person to be tested in great detail about what testing will occur. It also gives the following instructions to those to be tested:

> "In order to comply with agreed standards, please try not to:
> - Smoke for 24 hours prior to the assessment
> - Consume alcohol for at least 24 hours prior to the assessment
> - Wear clothing that substantially restricts full chest and abdomen expansion
> - Eat a substantial meal for at least 2 hours prior to the assessment
> - Take any short acting broncho-dilator drugs (eg ventolin/salbutamol) for at least 4 hours prior to the assessment if possible
>
> NB Even if you are capable, please do not partake of any vigorous exercise for at least 30 minutes prior to the assessment."

That guidance suggests that short acting drugs, among other things, may affect a spirometry reading. No warning or guidance about these is given to those attending an examination for assessment for PD 12.

*The relevance of pre-test medication to the test*

16 When granting permission to appeal, I asked the Secretary of State whether it was relevant to the statutory test for PD 12 that an individual was or may have been affected by ventolin or serotide or any similar medicine at the time of the lung capacity test. Dr Wright did not deal with this topic in his note for the Commissioner in CI 126 2002.

17 The reply again came from Dr Peter Wright. Besides being the Senior Medical Policy Adviser to the DWP, he is also an honorary consultant occupational physician at St. Thomas' Hospital, and has previously held other consultancy posts. He is

clearly an expert with wide experience in the field. Dr Wright's note in answer to my question stated simply "No, it is not".

18 Dr Wright explained the background to this reply in some detail by reference to the formulation of the statutory test by the Industrial Injuries Advisory council (IIAC). The IIAC is the official committee that advises the Secretary of State on these issues. He referred me specifically to paragraph 17 of *Chronic Bronchitis and Emphysema,* the second report under that title published by the IIAC. It was published in 1996 as Cm 3240. This was the report on which the Secretary of State based the regulations that set out the current test for PD D12. After a short discussion, the IIAC drew the conclusion that:

> "the normal use of bronchodilators by persons prescribed these by their doctors should not therefore interfere significantly with the results of FEV1 tests as a measure of the airflow limitation caused by chronic bronchitis and emphysema."

19 There are two qualifications in this formulation. It applies to "normal" use of bronchodilators, and it refers to no "significant" interference. Dr. Wright's comments suggest that "significant" might be judged against a claim for the prescribed disease assessed by itself. Because the disease is not present until there is a drop of FEV1 of 1 litre, there must be significant disablement before the disease is prescribable. But that does not, in my view, deal with the marginal case. And that is precisely what Mr J's representative argues that this case is.

20 In reply to this advice, Mr J's representative produced a report from Dr Robin Rudd, MA MD FRCP, a consultant in medical oncology at St. Bartholemew's Hospital. Again, he is clearly an expert with wide experience in the field. Dr Rudd directly challenged Dr. Wright's answer. In his explanation for that challenge, he commented that since the IIAC statement was made terminology has changed and knowledge has evolved. He referred at some length to *Chronic Obstructive Pulmonary Disease,* National Institute for Clinical Excellence (NICE) Guideline No 12, published at *Thorax,* 2004: 59(Supp 1) pp 1-232. (It is also on the NICE website at www.nice.org.uk). NICE (now the National Institute for Health and Clinical Excellence) is an independent body that issues guidelines on the appropriate treatment and care of people with specific diseases and conditions within the national health services of England and Wales. This Guideline was of course issued after Dr Denton undertook the test in question in this appeal.

21 Dr Rudd noted that COPD, as it is usually abbreviated, is a newer name for chronic bronchitis and emphysema. After quoting extracts from the Guideline, he concluded:

> "these extracts make it clear that responses to bronchodilator therapy certainly do occur in patients with COPD... hence, the advice of the IIAC that use of bronchodilators can be disregarded in determining whether the FEV1 criterion [is met] for the prescribed disease D12 is clearly unsatisfactory. There will be

substantial numbers of subjects who would fulfil the criterion on the basis of their FEV1 measured without prior use of bronchdilator but who would fulfil the criterion if it is measured after use of a bronchodilator.

... it would therefore be preferable for the prescription criteria to state that the FEV1 should be measured without prior use of bronchodilator. In practice this means at least four hours after the use of a short-acting bronchodilator such as salbutamol or terbutaline and at least 12 hours after use of a long-acting bronchodilator."

22 I offered Dr Wright an opportunity to reply. Dr Wright considered that he ought to draw the matter to the attention of the IIAC, and did so. He was of the view that the context of the Atos Origin guidance for the DTI and of Dr Rudd's report was that of civil litigation. He then set out his own views in full, concluding that he could not accept that the advice of the IIAC was unsatisfactory or out of date.

23 Both Dr Wright and Dr Rudd are widely recognised experts in their fields, and I intend no disrespect to the evidence of either of them, or the independent and expert public bodies on whose reports they rely, by curtailing my comments on their fully argued, and supported, answers as I have. It is clearly beyond my competence to decide whether those views are reconcilable and if not which is the better view. But it is also clear that there is room for different expert views on the issue. How should that be reflected in the decision on Mr J's claim?

*Prescription of PD 12*

24 The starting point is the formal terms of prescription. The prior condition set out in the Schedule is that the claimant must have chronic bronchitis or emphysema or both. Dr Denton made no finding about this, and nor did the tribunal. I can only assume that this was not in issue, but I can see no evidence of any diagnosis in the papers.

25 If that test is met, there must be "accompanying evidence" about the diminution of FEV1. As Dr. Wright noted, this wording does not require a spirometry test. As he recognised, in some cases that is not possible. Clinical practice suggests it is the best neutral evidence. That is clear from both the IIAC and NICE reports. It is therefore best practice to conduct the test. But it remains one form of accompanying evidence and no more than that.

26 Usually, therefore, there will be a spirometry test. CI 126 2002 requires that the test must be applied on the basis that the person being examined is not assisted during the test by any medication that would influence the test. It is his (or her) unassisted lung function that is in issue. In my view that must be right. It is the same kind of issue as getting the individual's height correct. When height is measured for the test, the individual should be asked to take any shoes off. Otherwise the formula, which takes into account the individual's height to the nearest centimetre, could be

applied with an error of several centimetres. In most cases that may not matter. At the margins it may be decisive.

27 I have summarised the disagreement about whether medication may affect lung function tests. Even the IIAC recognises that this is always of potential relevance. The passage quoted from the IIAC report refers to "normal use". And it does not define when medication may be "significant". The NICE and Atos Origin guidance notes suggest that the issue of significance may itself require professional evaluation in an individual case. So a medical adviser needs to check that, at the very least, there is no abnormal use of dilators when a test is conducted. I cannot see how that can be done if the medical adviser ignores the use of any medication, and I do not see how the standard test can be recorded properly without a note being made of this. The guidance given to those being examined for this test tells them to bring along their medicines, so the medical adviser can check this easily.

28 The law also requires that the test be applied fairly. Dr Rudd's view is that some people are being given the test under more advantageous conditions (to them) than others. If Dr Rudd is right, then some individuals will be disadvantaged because they did not stop taking medication because they are not warned about this. Others (perhaps those who were assessed for the DTI tests and then the DWP tests and followed the former guidance at the latter examination) may have not taken normal medication. Others could not stop taking it. Others, for whatever reason, may not have been taking it "normally". How fairness is achieved must be in part a medical matter. But the requirement of fairness, or in more formal terms of natural justice and of equality of arms, is one of law.

29 No relevant guidance is given to claimants ahead of a PD D12 examination. I find the explanation offered for the different notes of guidance given to the same people (miners) by the same people (the contractors to the DWP and DTI) ahead of the same tests (lung function tests) somewhat less than convincing. Be that as it may, tribunals should have in mind that individuals may or may not have been given guidance and may or may not have acted on it. They should therefore, to ensure fairness, directly check any necessary facts about pre-test medication if they conduct a test. They may also need to check that the medical adviser took appropriate note and account of any relevant medicaments when performing the original test. They should, at least in marginal cases, consider the possible effects of medication when forming a view about the conclusions to be drawn from the "accompanying evidence".

30 It is to be emphasised that the simple volumetric results of spirometry tests are not conclusive evidence for or against PD D12 of themselves. Tribunals, and therefore claimants, are entitled to expect rather more evidence of the original spirometry tests by a medical adviser than was produced to this tribunal in this case, or is allowed for in the standard forms used in this case.

*My decision*

31 That does not answer the key question in this case. Was the original test by Dr Denton fair to Mr J in the light of the objections raised for Mr J in his appeal? I reject the submission by the secretary of state's representative that I should reach my own decision. ? I cannot decide that because it involves medical issues. It is a decision for an expert tribunal. The tribunal has before it a full exposition of the two discordant views about the possible influence of medication on Mr J's lung function, but limited evidence of the original test. It is required by statute to decide the matter in the light of the circumstances as at 16 October 2003, and it must do so on the evidence available. If that evidence is inadequate for a clear answer, it must do the best it can in weighing the available accompanying evidence on the balance of probabilities.

David Williams
Commissioner

02 March 2006

[Signed on the original on the date shown]