INVALIDS OR MALINGERERS?: A QUESTION OF MEDICAL JUDGMENT

In *Morheb* and *Secretary to DSS* (No. N84/352) (decided on 13 October 1986) the AAT considered the problem of whether the applicant could be eligible for invalid pension where he appeared to only believe that he was sick. This raised the problem of psychiatric assessment of impairment. The case pointed out many inadequacies in this area.

The facts

Mr Morheb was aged 44 years. He arrived in Australia from Lebanon in 1971. He had a dependent wife and seven children. He was illiterate in both English and his native Arabic. He spoke limited English.

He was employed as a process worker from his arrival until 1975. In that period he was twice injured at work. He broke his thumb on one occasion and suffered a swollen wrist on another occasion. He was twice retrenched and eventually received less than $10,000 in worker's compensation.

In 1977 he was injured in a car accident. He subsequently complained of back ache and knee pain. In 1979 he was granted invalid pension. This was cancelled in 1984 and he was placed on sickness benefit.

The diversity of medical opinion

Mr Morheb had been seen by 12 doctors. Their opinions ranged from the view that he was significantly disabled to the view that he was a malingerer. The consensus, nevertheless, was that he would not work again.

The AAT effectively had to choose the view they preferred. Along the way the Tribunal made interesting comments with regard to invalid pension cases in general, and psychiatric disorders in particular.

'Medical' disability needed

The Tribunal referred to the history of the invalid pension and noted that it was introduced to assist those persons who suffered a 'serious illness or accident'. This suggested that a substantial *medical* condition is required and not an illusory one. The Tribunal referred to *Sheely* (1982) 9 *SSR* 86 and said:

> His Honour's allusion to the inappropriateness of applying the term 'invalid pension' to incapacitating conditions not properly falling within the realm of medical science might be extended to the benefits flowing under the Act being made available to a person who, while incapacitated from work, nevertheless is in such a condition because of a belief that he or she is sick.

(Reasons, p.6)

But is the belief a sickness in itself? And in any event, if the belief has arisen from a medical condition should that be sufficient to satisfy the eligibility requirements?

Clearly in *Morheb* the AAT thought not. The Tribunal remarked:

> By labelling an 'illness conviction' which defies medical science and lacks any true organic or psychiatric basis as having a 'psychological origin' and making the holder 'a mental invalid', a significant group of people who were, on our interpretation of the Act, never intended to receive invalid pension, would qualify for it.

(Reasons, p.9)

It was much more desirable, according to the AAT, to promote rehabilitation of such persons. To label them as invalid would only entrench their belief.

In *Morheb* the Tribunal preferred the medical evidence which took the view that there were no psychiatric factors present. This view labelled the applicant a malingerer. The psychiatrist who supported this view said the applicant was 'locked into a pattern of behaviour dictated by attitudes in the community, social influences and institutions, his cultural background, and his personality' (Reasons, p.16). But what does that mean? The words of John Kirkwood seem apt:

> Psychiatrists engaged by the Department of Health or the Department of Social Security often appear to pay too little regard to anxiety states or conversion reaction and concentrate on obsessional states, phobias and psychoses. The majority of invalid pension appeal cases involve non-Anglo-Saxon workers and the cultural and interpersonal factors in such migrant cases need to be given special consideration.

The applicant's counsel in *Morheb* had argued that the view of the applicant's own general practitioner who had had ongoing contact with him should be preferred. That doctor's opinion was that the applicant was sick.

But the AAT concluded that there was 'little scientific support' for the proposition that a treating G.P. would have a better understanding of the applicant's condition than a specialist who has seen him once. The Tribunal cited various articles which identified the variables which affect any doctor/patient relationship and the production of an accurate diagnosis. The AAT went so far as to suggest that a G.P. 'might indeed be cast into an advocacy role which lessens his or her objectivity' (p.18).

But the AAT did not consider the literature on the role of psychiatry and psychiatrists. As writers such as Laing, Szasz and others have argued psychiatrists too are affected by various factors. As Ivan Illich summarised their work:

> The psychiatrist acts as the agent of a social, ethical, and political milieu. Measurements and experiments on ... 'mental' conditions can be conducted only within an ideological framework which derives its consistency from the general social prejudice of the psychiatrist.
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> [*Limits to Medicine*, Penguin, 1976, p.173]

The absence of an organic basis

The Tribunal in *Morheb* concluded that the applicant's incapacity was due primarily to an '"illness" with no ascertainable biologic base arising from the social processes that have enveloped him as an industrial worker after a work injury'. (Reasons, p.20)

This desire to identify an organic basis before recognising his psychiatric condition is curious. Laing and Szasz may question whether mental illness is primarily organic at all. But even conventional psychiatric thought recognises psychiatric problems as ranging from organic brain diseases through to severe emotional and psychosomatic disorders and emotional disturbances.

If a psychiatrist defines 'malingering' does not the action of the psychiatrist make the condition 'psychiatric'? There was no suggestion in *Morheb* that the applicant was dishonest in his beliefs.

Which label?

At this point we are left with the vagueness of psychiatric diagnosis. But there are two further points which illustrate the inadequacies of the existing approaches in this area.

First, in *Morheb* the AAT considered that 'invalid' was not an appropriate label for the applicant. The alternative benefits were unemployment or sickness benefit. But how appropriate are those labels for a person who has not worked for over ten years and was unlikely to work again?

Second, the applicant was on sickness benefit at the time of the appeal. While the AAT did not directly comment on the appropriateness of that benefit, it appeared to place it in the same (rehabilitative) context of unemployment benefit. But is there not a contradiction in granting *sickness* benefit to a person who cannot be labelled 'invalid' because he is not really ill?

B.S.