CAS-54960-H9F8

Ombudsman's Determination

Applicant	Mrs N
Scheme	NHS Pension Scheme (**the Scheme**)
Respondent	NHS Business Services Authority (**NHS BSA**)

Outcome

1. I do not uphold Mrs N's complaint and no further action is required by NHS BSA

Complaint summary

2. Mrs N's complaint against NHS BSA concerns its decision to award her a Tier 1 ill health retirement pension (**IHRP**). She believes she should have been awarded a Tier 2 IHRP.

Background information, including submissions from the parties

3. Regulation 90 of the NHS Pension Scheme Regulations 2015 (SI 2015/94) (**the Regulations**) applies to Mrs N's application for an IHRP; relevant sections of which are set out in Appendix 1.

4. Mrs N worked for NHS BSA as a full time Clinical Coding manager. From June 2017, Mrs N was on sickness absence. On 4 June 2018, she submitted her application for an IHRP due to Sjogren's syndrome, bronchiectasis, fibromyalgia, depression and work-related stress and anxiety.

5. In her submissions, Mrs N provided medical reports from her treating doctors, relevant sections of which are set out in Appendix 2.

6. On 23 August 2018, the first instance decision maker, the Scheme's Medical Adviser (**SMA**) sent Mrs N a decision letter declining her application for an IHRP. The SMA concluded that:

> "The reports on file confirm the history and current status but give no indication as to treatability and prognosis, particularly in relation to the auto-immune complex. We wrote to the GP, Dr Patterson, on 3 July 2018 for further information but, to date, we have not received a reply…Because the applicant is 47, and has 20 years to run to the normal benefit age of her pension

scheme (67), we are not able to prognose the future over this length of time without further medical evidence concerning the future."

7. On 28 August 2018, Mrs N's GP provided the requested report to the SMA. This was dated 1 August 2018 and is set out in Appendix 2. On 3 September 2018, the SMA issued its revised initial decision and its view had not changed. This was because, although the GP's opinion was that Mrs N was likely to remain incapacitated for the foreseeable future, she had another 20 years until her normal pension age and there were treatments still available to her.

8. In January 2019, Mrs N appealed under the Scheme's Internal Dispute Resolution Procedure (**IDRP**). In her submissions, she said in summary:-

- Her condition had substantially deteriorated since her application.
- Her GP clearly stated that she would not be able to work for the foreseeable future. This meant permanently, not the SMA's interpretation.
- There was no cure for Sjogren syndrome and there was no remission, unlike with other auto immune diseases. She had taken medication for Sjogren syndrome for years until side effects kicked in with excruciating migraines. This disease would never improve and neither did its symptoms. The symptoms could only be managed to the point they were at that time, until further deterioration would occur.

9. She seemed to have exhausted all the treatments and was now trying a medication that was more commonly used for Lupus in the hope that it would help to halt the disease and stop the deterioration.

- She was unable to get out of bed, let alone attempt to travel or communicate with others, write or type.
- She suffered from clinical depression which was acute and chronic and was now a life-long illness.

10. On 6 March 2019, NHS BSA sent Mrs N a stage one IDRP decision that referred to its Medical Adviser's (**MA**) opinion that said in summary:-

- Mrs N's employment was terminated on 12 June 2018, so only medical evidence that would have been made available on that date had been used for consideration.
- The MA's opinion was that, at the time of Mrs N leaving employment, she had a physical or mental infirmity as a result of which she was incapable of efficiently discharging the duties of her employment. The key issue was in relation to whether Mrs N's incapacity was likely to be permanent.

- The MA considered that further medical reports, such as from Dr Bhalara, postdating Mrs N's original application could have been made available at the time of Mrs N's leaving employment.

- Based on the available evidence, at the date of termination of her employment, Mrs N was incapable of her NHS job and of regular employment of like duration. This was because of anxiety and depression, in the context of significant personal stressors.

- At that time, Mrs N had Sjogren's syndrome, gallstones with weight loss, functional neurological symptoms, fibromyalgia, vitamin D insufficiency, respiratory issues and carpal tunnel syndrome.

- The exacerbation in her physical symptoms was likely to improve with improvement in her mental health and with further specialist services management, and her mental health was likely to improve with reasonable treatment.

- However, given her multiple health issues and the significant demands of her NHS role, it was considered, on fine balance, to have been unlikely that she would recover sufficient overall health, function, resilience, and stamina to successfully return to her NHS role within the period to her normal pension age, even given full compliance with reasonable treatment.

- Although reasonable treatment was likely to take considerable time, it was considered that, at the date of termination of employment, Mrs N was likely to be clinically capable of and resilient to, retraining for and undertaking, less demanding, fulltime, regular employment within the 20-year period to her normal pension age, given compliance with reasonable treatment.

- The MA concluded that Mrs N was permanently incapable of her NHS employment. Therefore the Tier 1 condition was met. However, Mrs N was not permanently incapable of regular employment of like duration. So, the Tier 2 condition was not met.

- The MA did not recommend a reassessment of Tier 2 within the next three years or up to normal pension age, whichever was sooner. This was because there was no reason why Mrs N should not resume alternative employment. The reason for this was there was insufficient uncertainty regarding relevant functional prognosis.

11. In August 2019, Mrs N appealed under stage two of the IDRP. In her submissions, she said in summary:-

    - She did not accept that she was only unable to carry out her NHS role for the next five years under the Tier 1 condition. There was no cure for Sjogren's syndrome and her symptoms only deteriorated.

- NHS BSA had failed to take into account her depression and the fact that there was no cure for that either.

- She disagreed that she would be able to undertake an alternative employment on a full-time basis. She was prone to falling even using crutches and had difficulties in using public transport. She was unable to concentrate on daily living needs and get through each day due to her mental and physical incapacities.

- She would like to be reconsidered for Tier 2 IHRP as her condition was permanent, and this was confirmed by her specialists.

12. On 21 October 2019, NHS BSA sent Mrs N a stage two IDRP decision that maintained its previous stance. Its decision noted the opinion of a second MA. It said that:-

    - Changes to Mrs N's health and evidence postdating her termination of employment could not have been taken into account. Only evidence from 12 June 2018 had been considered.

    - Further treatments and medications would have been available to Mrs N at the time of her leaving employment. These were antidepressants of different types and further psychological therapy and management through specialist clinics which were recommended by her specialists.

    - Having another 20 years until her normal pension age of 67, with undertaking further treatments, Mrs N would be able to return to a less demanding full-time role, such as administrative or clerical duties.

13. NHS BSA said it did not see any reason to disagree with the MA's advice regarding not having the option for a reassessment in the next three years. Tier 1 award was appropriate and was not a perverse conclusion; that is, one which no reasonable body of people could have reached based on the same evidence.

14. In her submissions to The Pensions Ombudsman (**TPO**), Mrs N referred to her current health condition having not improved. She said during the Covid-19 pandemic, she had been classed as extremely vulnerable and placed in category four of the government list by her GP. She feels she is unable to undertake an administrative job due to her immune system being low.

Adjudicator's Opinion

15. Mrs N's complaint was considered by one of our Adjudicators who concluded that no further action was required by NHS BSA. The Adjudicator's findings are summarised below.

16. Members' entitlements to benefits when taking early retirement due to ill-health are determined by the scheme rules or regulations. The scheme rules or regulations determine the circumstances in which members are eligible for ill-health benefits, the

conditions they must satisfy and the way in which decisions about ill-health benefits must be taken.

17. Essentially, under Regulation 90 of the Regulations, in order to be eligible for a Tier 2 IHRP, in addition to meeting the Tier 1 condition, Mrs N must be permanently incapable of engaging in regular employment of like duration to her NHS role, until age 67.

18. The first instance decision was made by the SMA under a delegated authority from NHS BSA. NHS BSA acted on behalf of the Secretary of State who was the decision-maker under the Regulations. The Adjudicator was satisfied that the decision was made by the correct decision-maker, so the decision could not be challenged on this basis.

19. One of the specific obligations on the decision-maker was to consider all relevant evidence available to them and ignore all irrelevant information. However, the weight which was attached to any of the evidence is for NHS BSA, or the SMA in the first instance, to decide, including giving some of it little or no weight. It was open to it to prefer the advice of its own medical advisers unless there is a cogent reason why it should not, or, should not without seeking clarification. This might include errors or omissions of fact on the part of the SMA, or a misunderstanding of the relevant regulations.

20. NHS BSA's decision could only be made on the balance of probabilities. The Adjudicator noted that the first instance decision declined Mrs N's' application for an IHRP. Upon submission of further evidence at the stage one appeal, NHS BSA took account of Mrs N' additional medical evidence and awarded her Tier 1 benefits.

21. In the Adjudicator's view, NHS BSA appropriately considered the question of whether Mrs N would likely be permanently incapable of engaging in regular employment of like duration, in addition to meeting the Tier 1 condition until age 67, at stage one of the IDRP.

22. NHS BSA was required to consider the likely prognosis of Mrs N's condition at the date of her application. This required a forward-looking assessment on the balance of probabilities based on the evidence then available. NHS BSA was also required to consider any additional evidence which might be submitted during the IDRP that related to the condition as at the date of application. It was the Adjudicator's view that this is what had occurred in this case.

23. NHS BSA sought more than one MA's report after Mrs N submitted further evidence from her doctors in support of her application. The MAs' reports assessed Mrs N's conditions and her likelihood of returning to an employment of like duration.

24. Mrs N's original application was refused due to insufficient evidence that she was permanently incapable of her NHS role. During stage one of the IDRP, Mrs N provided further evidence and the MA was of the view that she was permanently incapable of her NHS employment, as it was too demanding for her mental and

physical conditions. However, the MA considered that, having 20 years until her pension age of 67, Mrs N would, on the balance on probabilities, be able to undertake an administrative or clerical job. This would be achieved with further treatments and medications still available to her.

25. In the MA's view, the exacerbation in Mrs N's physical symptoms was likely going to improve with an improvement in her mental health, through reasonable treatment and with further specialist services management. The MA considered that, at the time Mrs N's employment ended, she was likely to be clinically capable of and resilient to, retraining for and undertaking, less demanding, full time, regular employment before age 67. This advice was compatible with the advice of Mrs N's specialists provided at the time of her initial application. The MA at stage two of the IDRP agreed with the stage one MA's opinion.

26. The Adjudicator noted that some evidence provided by Mrs N which post-dated her original application showed that her condition had deteriorated in 2019 and she was unable to work again. The Adjudicator appreciated that Mrs N had referred to her current condition having deteriorated as stated in the most recent medical reports. However, NHS BSA's decision could only be assessed by reference to the medical evidence which was, or could have been, available at the time it was taken. Mrs N had to be able to satisfy the conditions set out in Regulation 90 of the Regulations, at the time her NHS employment ceased to qualify for Tier 2 IHRP.

27. In the Adjudicator's view, NHSA BSA had considered all the relevant evidence and abided by the Regulations. It had considered the relevant factors in arriving at its decision to award Mrs N a Tier 1 IHRP.

28. The Adjudicator appreciated that this would be disappointing for Mrs N but, in her opinion, there were no grounds for her to say that NHS BSA's decision was flawed or that the process it undertook in reaching its decision was incorrect. Consequently, it was the Adjudicator's opinion that this complaint should not be upheld.

29. Mrs N did not accept the Adjudicator's Opinion and, in response, provided further comments. In summary she said:-

    - Following an examination, an occupational health doctor agreed with her that she was unable to continue working because of her ill health. She questions why this decision from the only doctor to have examined her has not been taken into account.

    - NHS BSA has not taken account of her carpal tunnel syndrome. This has not been resolved and looks to have caused permanent damage because of delay. This makes any administrative role nearly impossible to undertake.

    - Due to her low immune system, she falls ill on a regular basis. This was highlighted by the pandemic. She questions how she could be expected to maintain any kind of full time employment if she were to be frequently off sick.

- Her current condition has not improved. She has not been able to work for the last five years. This cannot be disputed. The reference to a balance of probabilities cannot be maintained when the reality is clear for all to see.

- Sjogren's disease is a systematic autoimmune disease that affects entire body. She has been on pain patches and morphine to help with her pain. She provided articles from the Sjogren's foundation. Specifically, a summary of the patient survey regarding living with Sjogren's disease. This shows that symptoms have a major or moderate impact on patients' life. In addition, she has fibromyalgia and bronchiectasis. She uses two walking sticks and commuting would be impossible due to fatigue and germs.

- She feels "a huge miscarriage of justice being done here."

30. As Mrs N did not accept the Adjudicator's Opinion, the complaint was passed to me to consider. Mrs N provided her further comments which do not change the outcome. I agree with the Adjudicator's Opinion and note the additional points raised by Mrs N.

Ombudsman's decision

31. Mrs N is unhappy with NHS BSA's decision not to award her Tier 1 IHRP, and believes she should be awarded Tier 2.

32. It is not my role to review the medical evidence and reach my own decision about what level of IHRP Mrs N should be awarded. My role is to review the way that decision was reached, that is, whether the decision maker has obtained appropriate evidence on which to base a decision; whether the relevant regulations have been applied correctly; and, whether the decision is supported by the available evidence.

33. NHS BSA was required to assess Mrs N's eligibility for an IHRP in accordance with the Regulations, and to do so in consultation with its SMA.

34. NHS BSA was required to consider all relevant information and disregard all irrelevant information. However, the question of how much weight to attach to any of the evidence is for NHS BSA to decide. It is clear from the stage two IDRP decision that it gave most weight to the MA's opinion. That is, that the MA's comments indicated a clear expectation that, as at the time of leaving employment, Mrs N's condition was more likely than not going to sufficiently improve in order to undertake a less demanding job, of like duration to her NHS role, before age of 67.

35. Mrs N believes the Tier 1 award should be reviewed as the current evidence suggests she has not recovered sufficiently to look for work. She also questions the continued use of the balance of probabilities approach when she feels that it is now evidence that her capacity for work will not improve. But that is applying the benefit of hindsight. While it appears that Mrs N is not currently able to work, that does not mean that NHS BSA's decision was flawed at the time of the assessment. The

decision has to be assessed by reference to the expectations for Mrs N's future capacity for employment at the time.

36. I note that Mrs N considers that NHS BSA failed to take account of her carpal tunnel syndrome. However, this was referred to by the SMA at stage one of the IDRP and the expectation was that surgery would resolve this. This view was reiterated in the MA's advice provided at stage two of the IDRP and it was noted that Mrs N had been referred for surgery. Mrs N makes the point that delay (I take her to mean in treatment) looks to have caused permanent damage. This is, again, applying the benefit of hindsight.

37. Mrs N feels that more weight should have been given to the opinion expressed by the occupational health doctor who examined her. As has been explained, the weight to be attached to any of the evidence is for NHS BSA to decide, including giving some evidence little or no weight. The decision to give little or no weight to any of the evidence is not the same as failing to consider it. I note that the AW33E application form, containing the report from the occupational health doctor, was listed in the evidence considered by the SMA.

38. Based on all available evidence, no specialist had confirmed that Mrs N met the criteria for Tier 2 IHRP at the time of leaving her employment. Accordingly, I do not find that there has been an error in the way NHS BSA considered Mrs N's application for an IHRP.

39. I find that NHS BSA had considered all Mrs N's relevant medical evidence correctly and abided by the Regulations and there is no reason to remit Mrs N's case back to NHS BSA for reconsideration.

40. I do not uphold Mrs N's complaint.

Anthony Arter

Pensions Ombudsman
23 May 2022

Appendix 1

The NHS Pension Scheme Regulations 2015

41. At the time Mrs N's NHS employment ended regulation 90 provided:

"(1) An active member (M) is entitled to immediate payment of—

(a) an ill-health pension at Tier 1 (a Tier 1 IHP) if the Tier 1 conditions are satisfied in relation to M;

(b) an ill-health pension at Tier 2 (a Tier 2 IHP) if the Tier 2 conditions are satisfied in relation to M.

(2) The Tier 1 conditions are that—

(a) M has not attained normal pension age;

(b) M has ceased to be employed in NHS employment;

(c) the scheme manager is satisfied that M suffers from a physical or mental infirmity as a result of which M is permanently incapable of efficiently discharging the duties of M's employment;

(d) M's employment is terminated because of the physical or mental infirmity; and

(e) M has claims payment of the pension.

(3) The Tier 2 conditions are that—

(a) the Tier 1 conditions are satisfied in relation to M; and

(b) the scheme manager is also satisfied that M suffers from a physical or mental infirmity as a result of which M is permanently incapable of engaging in regular employment of like duration."

Appendix 2

Medical evidence

42. In her report dated 19 December 2017, Locum Consultant Rheumatologist, Dr Ammora said:

> "I reviewed this lady in clinic today. She reckons that there has been some deterioration in her symptoms including the fatigue and the general aches and also the dryness within her eyes and mouth. We have, therefore, agreed on escalating her Mycophenolate dose to 750 mg bd and we will keep an eye on her blood count. I have also given her a prescription for Salagen [Pilocarpine Hydrochloride] as highlighted above, again keeping an eye on her asthma symptoms. This should be stopped immediately if her asthma erupts.
>
> She has been reporting lots of weakness in the arms and legs and pins and needles. I have, therefore, booked an MRI scan of the cervical spine for her which hopefully will be ready when she meets the Neurology Team.
>
> Finally of note, she also mentioned lots of epigastric pain and abdominal bloating. This may well be IBS as a part of the fibromyalgia problem but I would be very grateful if you could look into this and consider an upper GI endoscopy.
>
> The lady will be reviewed again in clinic in six months time."

43. In her report dated 14 March 2018, Ms Manders at …Neuro Rehab Service, said:

> "During your last physiotherapy appointment, you complained of feeling generally unwell and I can see from your most recent conversation with.., our Occupational therapy technical instructor, that you have been diagnosed as having a problem with your gall bladder.
>
> Recommendations:
>
> Continue with the exercise and your general fitness programme as you feel able. You are likely to have to start again at the less challenging exercises after any illnesses and build up your tolerance gradually.
>
> You are aware of our self-referral system if you would like any further physiotherapy advice in the future."

44. In his report dated 26 July 2018, CT2 in psychiatry, Dr Yahya said:

> "Mrs N stated that she feels a lot better than when I saw her previously. Her mood tends to fluctuate on a daily basis. She described to me a structured routine, where she tends to keep herself busy with everyday chores. She also told me that she won the court case. However, this has not made her feel satisfied as the person who was guilty is still continuing their job. Mrs N has applied for an early retirement due to her physical condition. She feels that the

fibromyalgia and the Sjogren's syndrome has worsened. It is difficult to do even simple things at home, such as opening a jar. She mentioned that her son is with her all the time and basically acting as her carer and helps her a lot. She is due to see the rheumatologist specialist soon.

…

Mrs N is attending a psychotherapy session with… regularly. She can feel worse after the therapy and I mentioned to her that this is the effect of the therapy initially and this has showed that she is progressing. She feels that the therapy is helping. When asked about the drugs and alcohol, Mrs N said yesterday she drank two cans of cider and she does not normally drink alcohol. This might be due to the effects of the therapy. Otherwise, she denied taking any illicit drugs. Her sleep can be disruptive (sic), and this is due to the physical pain, and she has a good appetite.

Mrs N started taking Duloxetine 30mg as prescribed; however, she started developing side effects and after a discussion with her GP, she decided to stop it. We discussed the medication route and Mrs N feels that she does not want to have any medication at the moment. On assessment, she has the capacity to make decisions and I advised that if she is not coping, then we can always rethink about the medication.

Mental State Examination

Mrs N presented as a well kempt lady who maintained good eye contact and I believe we established a good rapport. She was tearful at times during the appointment. There was no psychomotor retardation. Her behaviour during the appointment was appropriate. There were no speech abnormalities. Her mood was low both subjectively and objectively. I could not elicit any hypomanic, manic or psychotic symptoms. Her concentration during the review was good.

I did not notice any thought interference. No psychotic symptoms were elicited and no perceptual abnormalities were detected. She denied suicidal thoughts and denied ideas of self harm and harming others. She is hopeful of her future and wants to get better and be stable in her mental health. She has good support from her family and they are her protective factor and she has good insight.

Recovery Goals and Actions (including lifestyle, employment and accommodation)

- Mrs N is aware of duty contact and mental health helpline numbers in case of psychiatric emergency.
- To achieve further improvement in her mental state through talking therapy.

- Discharge from the outpatient clinic. Mrs N agrees to let her therapist know if she is struggling and they will be able to refer her back to the outpatient clinic."

45. In her report dated 1 August 2018, GP, Dr Paterson said:

> "Her active medical problems include fibromyalgia, Sjogren's syndrome, depression, bronchiectasis. For her Sjogren's syndrome she is seeing a rheumatologist on a regular basis and is due to see them next in February. She is on Mycophenolate 750mg once daily. Regarding her depression, she is having fortnightly psychology and it was suggested that she start an antidepressant called Duloxetine but she was unhappy to commence due to stomach problems, namely gastritis.
>
> I only met this patient last October but actually I can see that she has been signed off work since last summer with depression and therefore I think that for the foreseeable future the prognosis is likely that this will continue and limit her ability to work. She is also in significant pain in her joints, particularly her hands and recent blood testing confirms that she appeared to be having a flare of her arthritis. I think this is further going to hinder her return to work and I cannot see that this would resolve any time soon.
>
> Regarding point 3, I think I have already answered this and I do not feel that I can put a timescale as to whether any improvement would be seen. Certainly, if it were to improve, it would be over a period of years I feel.
>
> Regarding point 4, I note that she had a transient ischaemic attack in 2011 and a pulmonary embolism in 2006 and she has also been found to be BRCA2 gene mutation positive so these possibly could cause future problems.
>
> Regarding point 5, I do not think that Mrs N's life expectancy is likely to be less than 12 months."

46. In his report dated 4 September 2018, Consultant Neurologist, Dr Foulkes said:

> "A few years ago she developed difficulty using her legs and now finds it difficult to walk. She says her legs feel like jelly when she walks. She has significant dysaesthesia in her legs. She walks with two sticks.
>
> Over just the last few months prior to the appointment she has developed tremors and involuntary movements in her arms. She gives the example that when she thinks she might need to get something out of the cupboard, she finds her arm is doing it before she consciously intends to.
>
> Separately, but also over the past couple of months, she finds that when she lies down and relaxes, for instance in the bed to go to sleep or on the sofa to watch TV she may have a sense of spreading numbness and tingling over her arms that gets worse until she feels unable to move her arms. Sensory disturbance comes down to the mid-thorax. She feels that she has to kick the

covers off with her feet and it may take an hour or two for the arms to return to normal use, she finds that her husband massaging her helps. Associated with these episodes is a heavy pressure on the back to her head which also remits her sensory symptoms.

Examination was unremarkable. The optic discs had normal appearances. She had a full range of eye movements with normal pursuit movements and saccades. There was no nystagmus. Movements of the face, tongue and palate were normal. There was good power in the sternocleidomastoids. There was no significant scalp allodynia. Tone and power were normal in the arms but she complained of shooting pains on initial contact, for example with her hands that caused her to withdraw. On the second attempt she generally tolerated my contact, for example when assessing grip strength, without evident difficulty. Reflexes in the arms and legs were normal. The ankle jerks seemed a little reduced compared to the other reflexes. Plantar responses were flexor bilaterally. Finger-nose pointing was normal bilaterally. Pin prick was perceived normally throughout the arms but was patchy over the shins and with allodynia in the feet. Vibration and joint position sense were normal bilaterally in the arms and legs.

Nerve conduction studies a few years ago showed bilateral carpal tunnel syndrome but no evidence of a large fibre neuropathy. An MRI of the brain (with contrast) at the NHNN in 2015 and a non-contrast MRI brain scan at Watford General Hospital in 2017, an MRI of the cervical spine at Watford General Hospital in 2017 were all normal. MRI of the lumbar spine in West Herts in 2015 showed possible impingement on the left L5 root.

I have explained to Mrs N that while some of the dysaesthesia in the hands and legs might be expected from a combination of carpal tunnel syndrome and/or small fibre neuropathy due to Sjorgen's and/ or vitamin D insufficiency, the majority of the symptoms she describes, such as not being able to move her arms when she lies down or when her arms appear to act before she intends them to, are more characteristic of a functional neurological disorder, due to the fluctuating nature of the symptoms and the normal examination and structural imaging.

I think it will be helpful to repeat the nerve conduction studies including the small fibre studies so that we understand what of her symptoms can be attributed with carpal tunnel syndrome and the small fibre neuropathy so that these can be treated appropriately. I will refer her to NHNN for assessment and treatment of the functional neurological disorder."

47. In his report dated 5 September 2018, Mr Bhalara (Consultant Rheumatologist) said:

"She is keen on further symptomatic treatment. She is not tolerating Tramadol particularly well. It might be worth trying her on opioid patches and I would recommend starting with a Buprenorphine Matrix patch at 5 micro-gr/hour

escalating slowly by 5 micro-gr/hour to about 20 micro-gr/hour. She has already tried a number of neuropathic pain agents and not been very successful with these. She hasn't, however had much in the way of non-Steroidal anti-inflammatories and that might be something worth pursuing. Certainly the osteo-arthritic hand symptoms may well respond to this. I would be grateful if you could start her perhaps on Naproxen 500mg bd or an alternative strong NSAID of your choice."