

Epistemic sabotage: The production and disqualification of evidence in disability benefit claims

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Funding information

Disability Benefits Consortium, Grant/Award Number: Is welfare unfair? qualitative study

Abstract

Disability benefits function by demarcating categories of need (the administrative category of disability) and determine eligibility using assessments of functioning. In the UK, these assessments are the Work Capability Assessment and PIP assessment. Inherently technical and abstruse processes, these assessments have been opportune sites for welfare reform in recent years. Disability benefits have also been a central point of contention between disability studies and sociology. Sociology has traditionally favoured an ‘incomes approach’ and called for more adequate financial support from the state. Early figures in the disabled people’s movement rejected this position, and aligned with an oppression paradigm, argued for a more radical economic and social inclusion. We contend that this divide, set out in the Fundamental Principles of Disability, remains relevant for researching welfare reform today. This article treats benefits assessments as epistemic practices—interactional processes wherein claimants, their personal health professionals and commercial assessment providers come together in the production of knowledge about disability. Data include 50 in-depth interviews with benefit claimants

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and a discourse analysis of official texts directed at claimants, personal health professionals and commercial assessment providers. We outline a phenomenon we term ‘epistemic sabotage’, whereby the knowledge claims of claimants and their health professionals are systemically disqualified.

KEYWORDS

disability benefits, disability studies, epistemic injustice, welfare reform

INTRODUCTION

UK welfare for disabled people involves income-replacement benefits and extra-costs benefits. Income-replacement benefits are paid through either *employment and support allowance* (ESA) or *universal credit* (UC). ESA was first introduced in 2008, replacing *incapacity benefit* (IB), and has since been superseded for new claims by UC. A second strand of financial supports are termed ‘extra-costs’ benefits, of which *personal independence payment* (PIP) is the mainstay. PIP was introduced in 2013, replacing *disability living allowance* (DLA). UC/ESA and PIP each involve assessments of physical and mental functioning, which act as gateways to support—these are the Work Capability Assessment (WCA) and the PIP assessment, both of which are overseen by commercial assessment providers.

Welfare systems function by demarcating administrative categories of need and use validity devices (assessments) to determine whether citizens are eligible to pass from the work-based system of redistribution into a needs-based system of redistribution (Stone, 1984). Benefit assessment regimes, such as the WCA and PIP assessments, enable authorities to reify the boundaries of disability as an administrative category, and provide a means of policing the border between work and welfare. Where these boundaries are drawn, and the ease by which claimants pass through, are political choices and do reflect of any essential aspect of impairment or disability. Disability benefit assessments, being inherently technical and abstruse processes, are therefore an opportune site for enacting welfare reform.

This article treats benefits assessments as epistemic practices—interactional processes in which claimants, personal health professionals and commercial assessment providers come together in the production of knowledge about disability. These constituencies have differing access to the concepts and language needed to successfully navigate benefit claims, and the knowledge claims emanating from each enjoy varying levels of credibility within the decision-making process. We analyse these dynamics using concepts derived from epistemic injustice (Fricker, 2007) and identify a phenomenon we term ‘epistemic sabotage’ whereby the knowledge claims of claimants and their personal health professionals are systemically disqualified. We draw upon a range of empirical sources, including in-depth interviews with 50 disabled claimants of UC/ESA and PIP and an analysis of official texts generated by the DWP and commercial assessment providers. In doing so, we revisit disability benefits as a long-standing point of divergence between disability studies and medical sociology. We seek not only to make visible the role played by disability benefits in the early divide between both disciplines but also to translate key points of that disagreement into our current analysis of welfare reform.

Medical sociology, disability studies and disability benefits

Medical sociology has traditionally approached disability by focussing on the situated experience of living with an impairment, the impact the condition has on an individual's life, the individual's sense of self and identity and on the management of symptoms and treatment. Disability studies has historically given a more materialist account, with attention placed on the social, economic, political and cultural barriers that serve to separate, exclude and disadvantage people with an impairment. Both approaches have produced useful and important understandings of impairment and disablement; however, both accounts are partial. This has been recognised by those working in disability studies (Shakespeare & Watson, 2001; Thomas, 2017) and medical sociology (Scambler, 2004; Williams, 1996), but too little cross-fertilisation has occurred despite notable attempts to reconcile the differences (Thomas, 2022).

Welfare reform is unusual in that it is one of the rare examples where both disciplines have tended to adopt a similar approach, particularly in the way they have explored the impact of cuts to services and provision implemented under the guise of austerity. Looking through the literature, it is difficult to discern any real theoretical or methodological difference in the way both disciplines address benefit reforms. Research includes work exploring the 'lived experience' of benefit cuts and sanctioning, and the consequences of these for claimant's physical and mental health (Saffer et al., 2018; Wright & Patrick, 2019); the stigma attached to long-term sickness benefits (Garthwaite, 2011, 2015; Moffatt & Noble, 2015); changing constructions of who is deserving of support, the restriction of disability as an administrative category, and the impact this has on claimants applying for benefits (Aarseth et al., 2016; Mik-Meyer & Obling, 2012; Roulstone, 2015). There are few discernible variations in the way the two disciplines have researched the topic or the conclusions they have reached; indeed, writers such as Garthwaite have published valuable contributions both in this journal (2015) and in *Disability and Society* (2011).

This convergence is perhaps ironic given the key role disability benefits played in creating the divide between the two disciplines. The root of this disagreement can be found in the *Fundamental Principles of Disability* (UPIAS, 1975): the text is frequently identified as having set out the maxim that disability is not caused by bodily impairment, but that 'it is society which disables physically [sic] impaired people' (UPIAS, 1975, p. 3). *The Fundamental Principles* is in essence the minutes of an ill-tempered meeting between The Union of the Physically Impaired Against Segregation (UPIAS) and the Disability Alliance (DA), an organisation founded by the sociologists Peter Townsend and Alan Walker. The disagreement, which played a key role in distancing the disabled people's movement from academic sociology, concerned not the definition of disability per se but rather the role of disability benefits.

The DA sought to bring together diverse disability groups under an umbrella organisation to campaign for a comprehensive state disability income (termed the 'incomes approach'). However, UPIAS saw this as a distraction, and argued instead that inclusion and participation, particularly in the workforce, were more important (termed the 'oppression paradigm'). Disability benefits were, according to the oppression paradigm, consistent with the logic of state charity, which maintained disabled people's dependence on the benevolence of non-disabled people. Indeed, for UPIAS, sociologists (such as those representing the DA) were part of the problem, not the solution:

The achievement of a national incomes policy would of necessity require an army of social administrators who would be given enormous power over physically impaired

people. In this way sociologists would oust the medical profession and replace them as the dominant group in the field.

(UPIAS, 1975, p. 18)

UPIAS claimed that sociologists had long been at loggerheads with the medical profession for oversight of disability policy and that sociologists had the most to gain from the ‘incomes approach’ to disability. With depressing accuracy, UPIAS also predicted the bureaucracy that would necessarily arise were non-disabled ‘experts’ to be installed as gatekeepers over a limited pool of financial support:

The scene facing every physically impaired person, then, is of an army of “experts” sitting on panels which are set up all over the country. These “experts”, armed with the latest definitions and tests for measuring, will prod and probe into the intimate details of our lives. They will bear down on us with batteries of questions, and wielding their tape measures will attempt to tie down the last remaining vestige of our privacy and dignity as human beings... Every single act would have to be performed in front of a panel while they measure and pry. Already the details are being worked out, the definitions constructed, criticised and reconstructed. It is a horrifying picture.

(UPIAS, 1975, pp. 17–18)

For sociologists working at the intersections of medical sociology and disability studies, *the Fundamental Principles* prompt important points of reflection. First, disability must not be individualised, meaning any methodological approach that emphasises individual social action (principally interpretivism) must also work analytically to make clear the role of disabling social structures. Secondly, a fair and sufficiently resourced benefit system is important, but this alone cannot guarantee an inclusive society. On the contrary, welfare systems may diminish independence where ‘experts’ are installed as gatekeepers of support. Finally, all campaigns on poverty and benefits (indeed all issues affecting disabled people) must genuinely involve disabled people, and must not be the preserve of a small number of non-disabled experts. We return to these principles in our final discussion.

Welfare reform and disability benefits

The groundwork for contemporary reforms to disability assessments was laid during Blair’s Labour administrations (1997–2007). The assessment regime for IB—the main out-of-work sickness benefit—was maligned as dysfunctional, and a broader cultural narrative labelling benefit claimants as morally deficient took root (Drake, 2000). These themes were clear in Labour’s *New Deal for Welfare* (DWP, 2006), which ostensibly addressed social security in general, but in reality focussed on out-of-work sickness benefits. The rationale for policy reforms set out in this document drew upon familiar principles of workfare—inefficient welfare structures, dysfunctional administrative processes and the impingement of citizen productivity by an overbearing state. The *New Deal for Welfare* (DWP, 2006) heralded ESA (replacing IB) and implemented a new assessment regime—the WCA. The Coalition Government (2010–2015) redoubled efforts to reduce both uptake and to increase out-flows from ESA. UC was the cornerstone of this programme, which saw six means-tested working-age benefits—including ESA—incorporated into a single payment. Despite ESA being subsumed within UC, the WCA remains standard for new UC claims and ESA reassessments alike.

The coalition Government (2010–2015) also made wholesale changes to extra-costs disability benefits, which are non-means tested and intended to meet extra costs all disabled people face in everyday life. By 2010, the Department for Work and Pensions (DWP) was concerned that too many DLA claims were being awarded without recourse to medical evidence (Machin, 2017), with eligibility often centring on confirmation of an individual's condition rather than its functional impact. Ministers criticised the DLA assessment over the central role afforded to claimant self-declaration and for supposedly granting lifelong awards without mechanisms for reassessment (Machin, 2017). These criticisms formed part of a broader cultural political economy (Jensen & Tyler, 2015), which depicted the social security system as being plagued by fraud, indolent claimants and an overly permissive bureaucracy. Popular tabloids fervently anticipated the Welfare Reform Act (2012), lauding its nascent reforms as a 'crackdown against workshy' and 'state-funded idleness' (Garthwaite, 2011, p. 370). The Act (2012) introduced PIP, replacing DLA, and the new 'PIP assessment' to be outsourced to commercial assessment providers.

The material impact of reforms to disability benefits is apparent in the fall in incomes experienced by disabled households compared to non-disabled households. Estimates suggest that between 2010 and 2021/22, disabled people lost £1201 each year due to changes in benefits eligibility and entitlements (DBC, 2019). However, the financial impact of reforms tells only part of the story, and a significant evidence base now details the impact of an increasingly stringent and punitive system upon claimant health and wellbeing (Wright et al., 2020). Shefer et al. (2016) report a deeply disempowering cycle of assessment, rejection and appeal that leaves claimants feeling disempowered and demoralised. Similar findings are presented by Shefer et al. (2016), whose respondents reported stress, feelings of hopelessness and having been labelled as 'scroungers'. Evidence also reveals that the impact of reforms is differentially experienced, with certain features of the benefits system being particularly inappropriate or inaccessible to different impairment groups. The transition from DLA to PIP has been particularly problematic for people with mental health problems (Machin & McCormack, 2021); the benefits system demonstrates a critical lack of understanding when it comes to fluctuating chronic conditions (Price et al., 2020); and people with learning disabilities face clear barriers such as inaccessible communications and inappropriate face-to-face assessments (Gray, 2017). Taken together, the picture is one of an increasingly hostile environment, which routinely harms claimants and has also been linked to an increase in deaths by suicide (Mills, 2018).

The branding of benefit claimants as 'skivers and scroungers' (Briant et al., 2013) and the vision of assessments as overly permissive helped establish a political and popular anti-welfare consensus. Countering these supposed ills were political appeals to evidence and reforms made to disability benefit assessments under the banner of objectivity (Porter et al., 2021). The public consultation over the new PIP assessment exemplified this, wherein the DWP (2010) set out its vision for disability assessment:

We want the new assessment to be objective and evidence-based, to ensure that support is targeted to those individuals whose health condition or impairment has the greatest impact on their day-to-day lives. A greater emphasis on objectivity and increased use of evidence will lead to more consistent outcomes and greater transparency for individuals, as the process will be easier to understand.

(DWP, 2010, p. 16)

In subsequent years, however, the role of evidence in the WCA and PIP assessments has been anything but clear. Successive independent reviews have criticised both assessments for not providing clear guidance about how to source and present effective supporting evidence

(Gray, 2017; Litchfield, 2014). In response, the DWP has taken steps that, they say, make the role of supporting evidence clearer (DWP, 2017a). However, the 2018 House of Commons Work and Pension Committee report into the WCA and PIP assessments found widespread and persistent concerns:

There is ongoing confusion amongst claimants and those supporting them alike about what constitutes “good evidence” for functional purposes. We recommend that the Department sets out... its approach to improving understanding amongst health and social care professionals and claimants of what constitutes good evidence for PIP and ESA claims.

(HCWPC, 2018a, p. 49)

Reforms to disability benefits cannot be understood without recognising the politics of evidence. Opponents of the welfare state depict benefit assessments as overly permissive, open to fraud and fundamentally unfair. In response, benefits policy has been shaped by popular (but ultimately specious) appeals to evidence, and assessment processes have been reformed in the misguided pursuit of procedural objectivity (Porter et al., 2021). In this article, we look at the production of evidence within benefit assessments and specifically at the form and status of knowledge claims emanating from distinct constituencies of actors. Disabled people, their personal health professionals and commercial assessment providers each produce, evaluate and communicate knowledge of disability; we seek to outline the institutional and administrative arrangements that shape these knowledge claims and explain how these arrangements function to deny the claims of disabled people.

Epistemic injustice and epistemic sabotage

Benefit assessments are epistemic practices—interactional processes, which see actors come together in the production, evaluation and communication of knowledge. Typical of most social practices, the behaviour of epistemic actors is shaped by contextual factors and is often characterised by an unequal distribution of power and resources. These latter political and ethical concerns have clear resonance within medical sociology and disability studies, which have in common the core concerns of an individual’s situated knowledge of bodies and impairment; and critiques of professional power and knowledge over those bodies. In recent years, the literature addressing the political and ethical dimensions of epistemic practices has burgeoned around the concept of epistemic injustice, which speaks to the wrongs endured by actors in their specific capacity as knowers (Fricker, 2007). As an analytic lens, epistemic injustice has been applied to studies of healthcare and illness (Carel & Kidd, 2014), disability (Leach Scully, 2018), and within this special issue, as a means of rapprochement between medical sociology and disability studies (Mladenov & Dimitrova, 2022). For our present purpose, epistemic injustice lends two sensitising concepts (testimonial injustice and hermeneutical injustice), which help delineate distinct concerns within benefit assessments.

Testimonial injustice occurs when an audience affords insufficient credibility to a speaker. Of particular significance to our project are cases of *systemic* testimonial injustices, where insufficient credibility judgements are tied to wider prejudices held by one agent (or group of agents) and concerning the credibility or capacity of another agent (or group of agents). As an illustration of testimonial injustice, we need look no further than sexist appraisals of the rationality of women,

or racist prejudgements about the intellectual capacity of non-white people, to recognise that one's status as an epistemic agent is closely linked to wider negative stereotypes. In the context of the disability benefit assessments, the clearest instance of an identity prejudice concerns the supposed inauthenticity of claimants. Disabled people seeking social security have historically been subject to pernicious misrepresentations as indolent and inauthentic; these tropes have also been a central motivating and legitimating force behind welfare reform in the past 15 years (Briant et al., 2013; Porter et al., 2021). Testimonial injustice calls attention to the identity of epistemic agents and the relative credibility afforded to their knowledge claims.

Hermeneutical injustice entails 'having some significant area of one's social experience obscured from collective understanding owing to a structural prejudice in the collective hermeneutical resource' (Fricker, 2006, p. 100). Hermeneutical resources are an individual's stock of cognitive and linguistic tools, which make their experience intelligible and communicable to others. To speak of a 'prejudice in the collective hermeneutical resource' (ibid) is to recognise that access to language and conceptual frameworks is unequal, meaning the ability to render one's experience intelligible is often contingent upon one's social position. Fricker (2006) illustrates this using the experiences of women subjected to inappropriate and unwanted sexual advances in the 1960s. At this time, the concept of sexual harassment was yet to be recognised, meaning the collective hermeneutical resource lacked the language needed to accurately describe sexual harassment. Consequently, a part of the victim's experience, Fricker contends, was a structurally imposed inability to comprehend or communicate their experiences to others. This observation reveals a distinctively epistemic dimension to oppression; a lacuna where the name of a distinct social experience should be (Fricker, 2006, p. 97). The consequences of hermeneutical injustice are not only epistemic disempowerment but also connect to wider oppression. As Leach Scully (2018) outlines, having one's experiences rendered unintelligible leads to a distorted sense of choices and goals, of right and wrong, meaning the foreclosure of agency and self-determination. As our findings section will outline, successful benefit claims often require a specific set of hermeneutic resources; success or failure hinge, for many, on the acquisition of concepts and language necessary to make disability intelligible according to a particular standard.

In this article, we proceed from a position that actors within the assessment process assume differing levels of credibility (testimonial injustice) and that the concepts and language needed to make disability intelligible according to the specific requirements of assessments are also unequally distributed (hermeneutical injustice). Throughout the findings section below, we argue further that these injustices are the result of administrative arrangements, which diminish the credibility of some actors, whilst simultaneously limiting access to requisite hermeneutical resources. We term this arrangement 'epistemic sabotage' or the disqualification of epistemic agents through orchestrated testimonial and hermeneutical injustice.

METHODOLOGY

The analysis we put forward presents the lived experience of benefit claimants, but also considers the relationship between knowledge and power, and how systems of signification inscribe the body, lived experience and social processes with meaning (Howarth et al., 2016). This focus on the discursive construction of disability assessment is needed because of the fundamental role played by the state in defining disability as an administrative category (Stone, 1984). In doing so, we seek not only to describe lived experience, but to account for the experience of claimants by identifying structural barriers that cause exclusion (UPIAS, 1975).

A range of empirical sources are drawn upon, including in-depth interviews with 50 disabled claimants of UC/ESA and PIP and analysis of official texts generated by the DWP and commercial

assessment providers. These official texts include media targeted at three distinct constituencies; benefit claimants; members of the claimant's own healthcare team; and commercial assessment providers. Interviews were conducted as part of a study funded by the Disability Benefits Consortium (DBC), which explored the impact of UK welfare reform on the lives of disabled people. The aim of this broader study was to understand how changes to disability benefits (including eligibility, rates of award, sanctions and conditionality) have been experienced by disabled people.

Participants were sampled purposively based on their having received UC/ESA and/or PIP and were recruited through advertisements placed in user-led organisations and affiliate members of the DBC. Study participants were aged between 21 and 65 years (average age of 45) and included 25 men and 25 women. The sample included six British Asian participants, one White non-British participant, one mixed-race participant and 42 White British participants. The sample was diverse in terms of impairment types, including physical impairments, mental ill health, sensory impairments and learning disability. Participants were asked to define their impairment(s), and each quotation presented in the findings section is accompanied by a description in these terms.

The focus of interviews necessarily involved topics that were sensitive and troubling for many participants. Several precautions were installed in order to minimise distress or limit any harm resulting from distress where it occurred. Prior to participation, all informants were provided with clear information about the focus of interviews, and all had the opportunity to ask questions before taking part. During interviews themselves, all members of research team made efforts to ensure that interviewees felt empowered, meaning participants understood that they were in control of what was discussed. Where participants expressed distress, they were reminded that the interview could be paused, terminated or that the topic of discussion could be changed. All participants (and particularly those who became distressed) were also signposted to information, support and advocacy (including welfare rights and user-led organisations). The host institution's Faculty of Medicine and Health Sciences research ethics committee provided ethical approval for the study (R205487).

A mixture of face-to-face and telephone interviews were conducted, and whilst each type of interview generated distinct data, the quality of interviews was assured by all interviewers having significant experience at the post-doctoral level. Interviews followed a topic guide that included questions about participants' personal and financial circumstances and their experience accessing benefits. Each member of the research team conducted interviews, which were transcribed verbatim. Data storage, administration and analysis were conducted using QSR Nvivo 11. Thematic Analysis (Braun & Clarke, 2006) provided the initial framework for analysing and coding interview transcripts, after which overarching categories were identified. This process resulted in a thematic analytic framework, which was reviewed within the research team.

Following this, we analyse the discursive and spatial formulation of texts, including DWP and commercial assessment provider documents, forms and videos. The majority of texts included in our dataset are available in the public domain, with two accessed using freedom of information requests. Taken together, these texts represent the official guidance available to benefit claimants, members of the claimant's own healthcare team, and commercial assessors. Our analysis of official texts follows Cooren's (2004) *textual agency*, which perceives a hybrid association between humans and texts. This approach emphasises the organisational and performative role documents play in shaping social practices. For Cooren (2004), texts display a form of agency by doing things humans alone could not do:

Created by human beings... texts participate in the channelling of behaviours, constitute and stabilize organizational pathways, and broadcast information/orders.

(Cooren, 2004, p. 388)

Our focus upon the discursive and spatial arrangements of these texts allows an analysis of the way disability is constructed within the assessment process and the corresponding standards of evidence these constructs entail.

Findings

In the following sections, we first present interview data and outline the experience of claimants as they source and present evidence in support of benefit claimants. We then analyse official texts directed at disabled claimants; claimants' personal healthcare professionals; and commercial assessment providers.

Sourcing and presenting evidence in support of benefit claims

When applying for UC/ESA or PIP, benefit claimants typically provide additional information or medical evidence in support of their claim. Interview participants spoke extensively about this process, and many reported seeking letters of support from GPs or hospital doctors as well as official confirmations of medications, treatment plans and the like. However, despite frequently citing the importance of supporting evidence, few were clear as to what constituted effective evidence:

Certainly getting a doctor's letter for ESA was very important, but they don't suggest things that you could put in

(Ellie, 55-year-old woman, ME)

Well they say provide as much evidence as possible but they don't specify what evidence they need.

(Joseph, 62-year-old man, epilepsy)

There was a clear sense among many participants that official guidance concerning the sourcing and presentation of evidence was lacking. Informants reported being told not to request bespoke evidence from their GP or hospital specialist because the DWP or private assessment providers would source this information independently. Paul, a 52-year-old man with cerebral palsy, spoke of his uncertainty and frustration following this advice:

The suggestion is that you don't need to provide additional medical evidence to the DWP... they say "let us have anything you've got, but don't go and search out anything new"... they say, "if we need evidence from medical professionals to support you, we will approach them, or we'll let you know".

(Paul, 52-year-old man, cerebral palsy)

Many informants chose to ignore DWP guidance and instead sought supporting statements from members of their own healthcare team. For most, this represented hard work, which took a physical and emotional toll and often entailed financial costs in the form of administrative fees. Riya, a 45-year-old woman who is registered blind, spoke of the work involved in arranging evidence in support of her ESA claim:

It was such a long-winded process ... it's not just filling in the form and sending it off, it's also collecting evidence. I have to go to the GP, get a letter from the GP; have my

eyes tested; get a letter from the optician. So there are a few other bits and pieces of evidence I have to submit and it involves a lot of running round.

(Riya, 45-year-old woman, registered blind)

Several participants reported difficulty securing evidence from own healthcare team, particularly evidence that explicitly addressed the criteria of assessments, such as their work capability:

I've asked my neurologist for PIP last year and for ESA this year... I have been told I would need him to write a particular statement about it affecting my ability to get out and work... I didn't quite know what he was going to do, but he agreed to help me as I was so desperate... they [health professionals] do not want to get involved with DWP... I can see that he's tried to address it, but he wouldn't actually write the sentence that I was asked to get him to write. It's so specific though, it's asking him to say that I cannot work.

(Lisa, 48-year-old woman, chronic migraine; fibromyalgia; anxiety and depression)

The prospect of securing supporting evidence was especially problematic for participants with fluctuating conditions, learning disability, mental illness, stigmatised conditions and medically unexplained symptoms. George, a 51-year-old man with a long-term neurological disorder, explained that the medically unexplained nature of his illness made it difficult to provide effective evidence:

How can I produce evidence when you don't even understand the disease? Or you've lied about my disease for years? Now they're realising but what evidence can I produce? There's no treatment for me.

(George, 31-year-old man, neurological disorder)

A more general criticism of medical evidence was its neglect of the functional aspects of disability. Harry, a 47-year-old man with multiple musculoskeletal conditions, stated clearly that medical evidence conceived of disability in narrow terms, meaning it was of limited use for his ESA claim:

Medical reports do not put in anything about how a condition affects a person on a day-to-day basis... they're writing medical reports based on blood tests, x-rays, MRIs... That's all they do, that's what their focus is on: what the condition is, what's shown in the analysis and what's in the treatment plan. It doesn't say "Person A cannot walk 10 meters". It never says that, that is not their focus.

(Harry, 47-year-old man with multiple musculoskeletal conditions)

The experiences outlined here mirror those reported in independent reviews of the WCA and PIP assessment (Gray, 2017; Litchfield, 2014), which have found guidance for claimants to be lacking. Claimants clearly recognise the importance of supporting evidence, but few understand what constitutes effective evidence. In the next section, we contextualise these findings by examining official guidance directed at claimants.

DWP official guidance to claimants

Key to the functioning of the WCA and PIP assessment are official texts directed at distinct constituencies. These texts exert an organisational agency (Cooren, 2004) over different actors

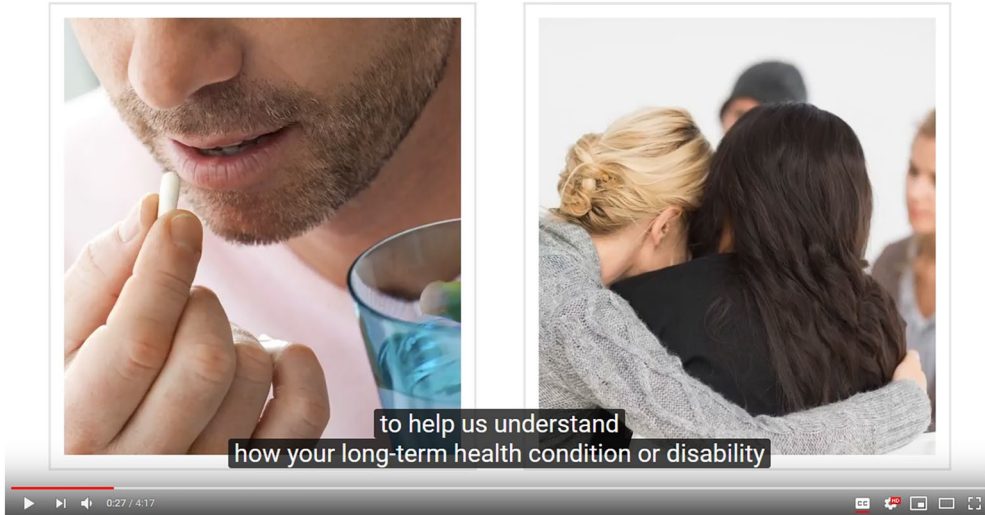


FIGURE 1 Image from the DWP Youtube video entitled ‘Personal Independence Payment—providing information to support your claim’ (DWP, 2018).

within the assessment process, shaping both the knowledge they produce and their evaluation of other epistemic agents. In this section, we introduce two texts directed at claimants and consider the constructs of disability they advance and the standards of evidence they involve. The first is a DWP Youtube video, which advises PIP claimants; the second is the UC50 (the work capability questionnaire) (Figure 1).

The following transcript is taken from the DWP’s Youtube channel and a video entitled ‘Personal Independence Payment—providing information to support your claim’ (DWP, 2018). After introducing the video, the male narrator addresses claimants in a calm and reassuring tone:

You need to send us supporting information with your claim, to help us make a decision on your claim more quickly. Most people will need to attend a face-to-face assessment. Information relevant to your claim is really important to help us understand how your long-term health condition or disability (both mental and/or physical) affects you day-to-day.

Send us the different types of information that you have, this doesn’t have to be medical details. Information from someone who supports you, like a nurse, social worker or carer is really helpful too.

(DWP, 2018)

Three distinct messages are conveyed in this excerpt, which together encapsulate the way disability and standards of evidence are constructed within claimant-directed texts. First, whilst the video states clearly that most applicants will need to attend a face-to-face assessment, it also implies that the information claimants provide will play a central role in the DWP’s decision-making process. Second, disability is framed in everyday terms as the applicant’s lived experience and the effects of illness or impairment on ‘day-to-day’ life. Third, viewers are assured that the supporting information they provide need not be ‘medical details’, rather a more holistic notion of evidence

is put forward. The same video then proceeds to detail what does, and does not, constitute 'relevant' supporting information:

Here are some examples of relevant supporting information you should send in with your *form*, if you have them: *social care plans; reports from health professionals; test results; statements from carers or family; prescription lists...*

You generally don't need to send: appointment letters or cards; general information or factsheets about your condition or medication; and bus or train tickets to appointments you have attended.

(DWP, 2018)

Here, the inclusive notion of evidence is further advanced, with the testimony of claimants, their family members and carers are all identified as valid.

Despite asserting the importance of claimant-sourced evidence, a reoccurring feature of texts directed towards claimants is the ambiguous, often contradictory, guidelines concerning the role and responsibility of claimants. The UC50 advises applicants about the provision of information in the following terms:

Please tell us about your GP. If you don't know your GP's name, tell us the name of your doctor's surgery. Sometimes we will need to contact them to ask for medical or other information that tells us how your disability, illness or health condition affect your ability to do things on a daily basis. We don't always have to contact them, so it's important that you send all of your medical or other information back with this questionnaire.

(DWP, 2017b, p. 4)

Claimants are told to provide the name of their GP, but the function of this information remains unclear as the document also states that GPs will only be contacted 'sometimes'. Applicants are assured that the information they provide is important, and an inclusive conception of evidence is implied by the reference to claimants' 'ability to do things on a daily basis'—the same quotidian referents as the PIP guidance (above). Similar ambiguity concerning the role of claimants in sourcing evidence is also apparent in the PIP video (DWP, 2018), which instructs applicants to:

Just send photocopies of what you already have. It's your responsibility to send this to us, but please only send us copies of what you already have. Don't contact your GP or health professional for new or additional information as they may charge you for this. If we need more information from your GP or other professionals involved in your care we will ask for it ourselves.

(DWP, 2018)

Claimants are told that it is their responsibility to provide supporting information, yet they are instructed not to request new evidence from their GP. Instead, claimants are advised to provide copies of unspecified existing information before being told that assessors will independently source evidence from the claimant's healthcare team if needed. Such mixed messages can, understandably, lead to anxiety and confusion among claimants and are likely to explain the concerns of participants outlined in the interview data presented above. Ambiguity is found not just in relation to the responsibility of claimants, but also in terms of the nature of the evidence itself. Official guidance implies that the construct of disability under assessment is the lived body/mind,

involving a correspondingly inclusive notion of evidence in which the testimony of claimants, their family members and carers are all considered credible. As we will demonstrate, these assertions fundamentally misrepresent the way disability is assessed.

DWP guidance to claimants' healthcare team

Once benefit claims are submitted, medical evidence may be requested from the claimant's own healthcare team (typically their GP or hospital doctor). As outlined above, claimants are instructed by the DWP not to request this information themselves; instead, evidence from claimants' own healthcare team is solicited on behalf of the DWP by private assessment providers using evidence pro formas. These pro formas and accompanying guidelines construct disability and standards of evidence that are distinct from those of the lived body/mind; we argue further that these texts employ techniques that limit the scope of health professionals to testify to the functional criterion of assessments—a contrived hermeneutical injustice. Below, we report on the UC/ESA evidence pro forma (DWP, 2016), the Capita PIP evidence pro forma (CAPITA, 2019) and the accompanying DWP guidebook for health professionals on completing factual reports (DWP, 2019).

Figure 2 shows the first page of the UC/ESA evidence pro forma (DWP, 2016). This page contains a free-text table in which GPs are asked to report 'details of those conditions **that may have a significant effect on the person's capacity to work**' (original emphasis). Importantly, no further guidance is given about what type of work this refers to or whether the hypothetical work in question involves an accessible workplace.

Despite the ambiguous nature of work and the workplace, the instruction to report the claimant's capacity to work is emboldened. This arrangement calls for a definite response, yet the form gives no context about the accessibility of work or the workplace upon which to base such a firm judgement. A dissonance is promoted, therefore, between an ambiguous construct of work and the demand for certitude on the part of respondents. Without explicit examples upon which to base judgements of work capacity, it is possible to imagine accessible work environments, meaning work capacity becomes increasingly plausible for many. This arrangement is likely to promote equivocal responses.

The subsequent free-text table contains three pre-defined columns: 'Conditions and date of diagnoses', 'Symptoms and signs', 'Investigations and management, including medication'. This arrangement formulates disability as a clinical object—biomedically imagined and impairment focussed. Here again, context is absent, with no scope to indicate how diagnoses or impairments interact with particular employment settings or with claimants' social or cultural circumstances. Disability—as the interaction between impairment and disabling barriers—is written out of the text.

The following page of the ESA13 form (Figure 3) addresses functional aspects of disability through a series of vertically arranged tick-boxes. These boxes have an unclear relationship to the immediately adjacent free-text box, which asks respondents to 'provide a brief explanation'. Whilst ostensibly giving opportunity to report functional disability, it is important to recognise that respondents may be less likely to complete a second free-text box in a comprehensive way, having already completed the preceding free-text table (page 1). The form makes no attempt to ground functional limitations in real-world examples, meaning again that the resulting testimony is likely to be inherently vague and will focus on impairment rather than functional disability. This reading is consistent with the accounts of interview participants above, who spoke

Your reply

Please complete **both** sides of this form, then send it back to us in the envelope we have sent you. Make sure the address below shows in the window of the envelope.

Office contact name and address:

Client's name

Client's NI number

Client's date of birth

Please answer the following questions from the information which is currently available to you. If you need more space for any of your answers, please continue at **Part 7**.

1 When did your patient last see a GP?

2 Current conditions affecting ability to work
Please give us details of those conditions **which may have a significant effect on the person's capacity to work**.

Please include:

- Relevant symptoms and signs, including side effects of medication, with dates. For mental health conditions, please provide brief mental state examination findings, if available.
- Past, present and planned investigations and management, including medication, **where relevant**. If you are sending a computerised printout of current medication you do not need to list this here.

Condition and date of diagnosis	Symptoms and signs	Investigations and management, including medication

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FIGURE 2 ESA113 form (DWP, 2016), page 1 of 2

about the limitations of medical evidence in precisely these terms. These same features are also apparent in the corresponding PIP evidence pro forma (CAPITA, 2019), which seemingly gives greater opportunity for statements of functional limitations or the ‘effects of the disabling condition(s) on day to day life’ (Figure 4).

However the accompanying DWP guidebook gives specific instructions for the completion of this question, stating:

Your reply continued

3 Current conditions not affecting ability to work
Please list any other relevant conditions that do not affect the ability to work.

4 If known from your knowledge of the patient, please tick the boxes that apply and provide a brief explanation if your patient has difficulties with any of the following activities:

Walking or moving	<input type="checkbox"/>	
Transferring between seats	<input type="checkbox"/>	
Reaching	<input type="checkbox"/>	
Picking up objects	<input type="checkbox"/>	
Manual dexterity	<input type="checkbox"/>	
Communicating with others	<input type="checkbox"/>	
Continence	<input type="checkbox"/>	
Learning simple tasks	<input type="checkbox"/>	
Awareness of hazards	<input type="checkbox"/>	
Initiating and completing personal actions	<input type="checkbox"/>	
Coping with changes or social engagement	<input type="checkbox"/>	
Appropriateness of behaviour	<input type="checkbox"/>	
Eating or drinking	<input type="checkbox"/>	

5 Does the patient have a history of threatening or violent behaviour? No
Yes Tell us about their behaviour within the last 5 years, and whether they have been identified by the Zero Tolerance (Violent Behaviour) Initiative. Use the space below at Part 7.

6 Could your patient travel to an examination centre by public transport or taxi? No Please tell us why at Part 7.
Yes

7 Additional information
Please continue on a separate sheet if necessary.

The information you have given us may be copied to the patient, their legal representative or the Tribunals Service.

Your signature

Name IN CAPITALS

Date

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FIGURE 3 ESA113 form (DWP, 2016), page 2 of 2

We are looking for facts, not opinion, with the date of the observation. If you would like to offer your opinion, please make sure it is supported by factual evidence.

(DWP, 2019, p. 10)

'Facts' and 'opinions' are not neutral terms, both are implicated with the professional and ethical values of medicine, particularly for clinicians trained in evidence-based medicine, which gives primacy to randomised control trials and affords lowly status to expert opinion (Kerridge et al., 1998). This framing transforms respondents' testimony into a moral exercise, as their statements of support risk being deemed unprofessional should they stray from fact into opinion. This discursive dynamic can only promote doubt and encourage circumspect responses. A more explicit factor in this arrangement is the requirement that 'facts' be accompanied with 'the

6. Effects of the disabling condition(s) on day to day life

If known, it would be helpful to have information on the patient's ability to:

- Manage their health conditions and treatment
- Communicate
- Walk or move around
- Get somewhere on their own
- Make simple decisions
- Prepare, cook and eat food
- Wash, bathe and use the toilet/ manage incontinence
- Dress and undress

Only include information that has been confirmed by a health professional. Please state if this is not known.

7. Does the patient have a history of threatening or violent behaviour?

No Yes Don't know


If yes, tell us about their behaviour within the last 5 years. Use the space below at Part 9

8. Could your patient travel to an assessment centre by public transport or taxi?

Yes No Don't know

If no, please tell us why. Use the space below at Part 9

Capita Business Services Limited
Registered office: 30 Berners Street, London, W1T 3LR, United Kingdom
Registered in England No 2299747
Part of Capita PLC



Providing assessment services on behalf of
Department for Work & Pensions

FIGURE 4 Capita PIP Factual Report (CAPITA, 2019), page 6 of 11

date of observation'. This requirement clearly precludes statements about functional limitations based on logical inferences alone. Instead, for statements to be valid, and ethical, they must be accompanied by empirical observations. Given that interactions between responding clinicians and claimants will typically occur in clinical settings, this requirement places clear limitations on the scope of the clinician's testimony, at the direct expense of functional aspects of disability.

In summary, evidence pro formas and accompanying guidance exert organisational agency over claimants' personal health professionals. These texts encourage medicalised evidence that is impairment-focussed, whilst also seeking to limit testimony about disability as the functional interaction between impairment and environment. We explain the full implications of this arrangement in the following sections.

Private assessment providers

The outsourcing of disability assessments to commercial assessment providers has been a central feature of welfare reforms (PIP assessments are conducted by Capita and Independent Assessment Services, i.e., ATOS; WCA by Health Assessment Advisory Services, i.e., Maximus). These commercial assessment providers are the third audience for official texts, which not only

construct disability in markedly different ways but also actively undermine the evidence solicited from claimants and their personal health professionals. The WCA handbook (CHDA, 2020) sets out how assessors should regard the testimony provided by claimants' own healthcare team:

The primary role of the GP or hospital doctor is to diagnose and treat any medical conditions that the patient/claimant presents to them. Any information or medical report that the doctor provides to the DWP in relation to disability benefits is a purely secondary activity to his/her therapeutic role. A clinician does not routinely consider the functional restrictions or disabling effects of the medical conditions that they treat.

(CHDA, 2020, p. 49)

This passage reveals the interplay between hermeneutical and testimonial injustice, as the credibility of personal health professionals is denigrated (testimonial injustice) for not adequately comprehending functional disability (hermeneutical injustice). Having limited the scope of claimants' own health professionals to testify to the functional limitations of their patients, here the credibility of that testimony is undermined for being clinically focussed and not addressing disability. This is an act of epistemic sabotage.

Private assessment providers are the only actors with full access to the hermeneutical resources needed to evidence disability effectively, and only their testimony is deemed credible by DWP decision-makers. The following excerpt is taken from a section of the WCA handbook addressing manual dexterity, and illustrates clearly that what constitutes effective evidence is directly at odds with the guidance issued to claimants and their healthcare teams. The WCA handbook outlines the following scheme of evidence in relation to manual dexterity:

- Physical examination

In addition to the examination of the upper limbs as subsequently described, always inspect the hands carefully and document any evidence of ingrained dirt or callosities, indicating the possibility of some heavy domestic/manual work at some point in time

(CHDA, 2020, p. 95)

- So called 'informal observations'

You may have the opportunity to observe how the claimant handles tablet bottles, their expenses sheet or a repeat prescription. You may also observe them lifting objects such as a pen, handling a newspaper/book, handling a mobile phone, drinking from a bottle, etc. Fine movements may be observed if the claimant adjusts their spectacles or their hair, or scratches their head.

(CHDA, 2020, p. 95)

- Legal boundaries

An upper tribunal decision (DG v SSWP (ESA) [2014] UKUT 100 (AAC) has clarified that activity 5/M(d) can only apply if a claimant is unable to use both a keyboard and

mouse. So if a claimant can use either a keyboard or a mouse with one hand, activity 5/M(d) will not apply.

In the context of activity 5/M(d), only one hand is required to adequately operate a keyboard. The upper tribunal have dismissed claims that use of a keyboard requires the use of both hands.

(CHDA, 2020, p. 95)

This is the construct of disability assessed by the WCA and PIP assessments: administratively constructed, surreptitiously observed, and legally bound. It is a construct of disability accessible only to commercial assessment providers, and neither disabled claimants nor their personal health professionals may claim to know this body/mind in a credible way. The testimony of private assessors achieves credibility in a way no other testimony can because it is ostensibly functional (unlike claimants' own healthcare team); true (supposedly unlike claimants); and legally permissible at the time assessments take place.

DISCUSSION

The WCA and PIP assessments have been central to the welfare reform programmes of successive UK governments. Evidence has played a key role, both practically and symbolically, in surrounding debates and in reformed assessment regimes (Porter et al., 2021). In practical terms, each step of the assessment process has become increasingly standardised, and both the WCA and PIP assessments give ultimate weight to the testimony of outsourced 'independent' assessors. The symbolic function of the government's appeal to evidence lent welfare reforms a degree of methodological legitimacy, with connotations of greater validity and reliability, meaning new assessments appeared fairer. But independent reviews and parliamentary investigations into the WCA and PIP assessments have shown that evidence—what constitutes effective evidence and how it should be sourced and presented—is a central point of confusion among claimants and health professionals alike (Gray, 2017; HCWPC, 2018a; Litchfield, 2014).

This article has examined the experience of sourcing and presenting evidence during benefit claims. As identified by independent reviews (Gray, 2017; Litchfield, 2014), participants in this study understood the importance of supporting evidence, but few had any sense of what constituted effective evidence. In line with the UPIAS (1975) call to avoid individualised accounts of disability, this study contextualised these interview findings with an analysis of official guidance concerning supporting evidence. By exploring the discursive production of evidence within these texts, this article has put forward the concept of epistemic sabotage or the systemic disqualification of epistemic agents through orchestrated testimonial and hermeneutical injustice (Fricker, 2007).

Texts directed towards claimants employ quotidian framings to construct disability as lived and advance correspondingly inclusive standards of evidence. Despite asserting the importance of claimant-sourced evidence, a reoccurring feature of these texts is the ambiguous, often contradictory, guidelines concerning the role and responsibility of claimants. It is here that epistemic sabotage begins. Firstly, claimants are led to believe that their experiential knowledge will be deemed credible, and secondly, no attempt is made by authorities to support claimants in translating their experiential knowledge into evidence that complies with the technical framings of

functioning employed by assessments. This arrangement sets in place the conditions for subsequent testimonial and hermeneutical injustices, as the knowledge claims of disabled claimants are not routinely deemed credible (indeed, they are treated as inauthentic by default), and their experiential knowledge necessarily fails to comply with each assessment's technical framing of disability.

The second audience for official texts are members of claimants' own healthcare team. Claimants are instructed by the DWP not to request new evidence from their personal health professionals; instead, evidence from claimants' own healthcare teams is solicited on behalf of the DWP by private assessment providers using evidence pro formas. These texts exert organisational agency over responding health professionals, and construct disability as a clinical object according to diagnoses, signs and symptoms. Where space is afforded to the functional aspects of disability, these texts encourage circumspect, equivocal responses—thus limiting the scope of claimants' own health professionals to testify to functional aspects of disability. This represents a further instance of epistemic sabotage, as a distinctive stock of hermeneutical resources is promoted whilst others are discouraged. In constructing disability as a clinical object, these pro formas generate evidence that, again, necessarily fails to address disability as it is truly constructed by each assessment.

The final audience for official texts are commercial assessment providers. These texts not only construct disability in markedly different ways from those outlined above but also explicitly undermine the evidence solicited from claimants and personal health professionals. This is the final and clearest instance of epistemic sabotage. Whilst texts directed towards claimants construct disability as lived and imply inclusive standards of evidence; texts directed towards commercial assessment providers depict claimants as inauthentic and untrustworthy. Guidance directed towards claimants' own healthcare team constructs disability as a clinical object; yet texts directed towards commercial assessment providers criticise medical evidence in these precise terms.

Texts directed at commercial assessment providers also reveal disability as it is truly constructed by benefit assessments. The disabled body/mind under assessment in the WCA and PIP assessments is imaginary—administratively constructed, surreptitiously observed and legally bound. Both assessments purport to be assessments of functioning, but neither assesses functioning as is typically imagined to be the interaction between impairment and real-world environments. Instead, the disabled body/mind under assessment exists only administratively as the interaction between contested impairments with unreal tasks and environs, all of which are framed by the latest legal ruling as to what is (un)permissible at a given moment in time. This is not disability as lived or cared for, meaning neither disabled claimants nor their personal health professionals are able to stake credible claims to know this disability. Importantly, the confusion experienced by claimants and health professionals (HCWPC, 2018a) over what constitutes effective evidence is not due to a deficit in either parties' knowledge or understanding—this too is an illusion. Both parties are confused, but their confusion stems directly from the epistemic sabotage outlined in this article.

The Fundamental Principles (1975) discussed at the outset of this article gives insight into an early moment in the fractious relations between disability studies and UK sociology. The disagreement between UPIAS and the DA centred upon the role of disability benefits, but this issue reflected a much deeper ideological divide between the Fabian ideals of Peter Townsend and British sociology on the one hand, and the radical and participatory disabled people's movement on the other (Beresford, 2010). UPIAS argued that disability benefits in isolation simply

ameliorated the symptoms of oppression rather than addressing the fundamental social and economic exclusion of disabled people. Their demand was that disabled people be in control of all matters affecting their lives, from their day-to-day support arrangements to the conception and delivery of national social policy. The benefit apparatus set out in this article reveals a bureaucracy that actively contrives to disqualify disabled people and their health professionals as epistemic agents. Of course, any genuine attempt to know disability would value and meaningfully incorporate disabled people's experiential knowledge of impairment and functioning; that their knowledge claims are systemically excluded belies an oppressive system, the ultimate purpose of which is not to support disabled people, but rather to police the boundary of disability's administrative category. UPIAS (1975) forewarned that an oppressive bureaucracy would arise were non-disabled experts installed as gatekeepers of support, and whilst the *Fundamental Principles* failed to anticipate the rampant privatisation that subsequently ensued, its broader diagnosis of exclusion and prescription of participation remains vital. Rectifying the benefits system (or at least resisting it in its current form) will be possible only with the radical embedding of welfare rights and the full participation of disabled people. Disabled people's knowledge must be central to the benefits assessment process, as it must be to all research, policy and campaigns affecting the lives of disabled people. This was the clarion call of the *Fundamental Principles*, which inspired disability studies and must continue to challenge and improve sociology today.

AUTHOR CONTRIBUTIONS

Tom Porter: Conceptualization (Equal). **Nicholas Watson:** Conceptualization (Equal). **Charlotte Pearson:** Conceptualization (Equal).

DATA AVAILABILITY STATEMENT

The availability of data used in this article varies according to type: the data supporting the discourse analysis is available in the public domain and is detailed in the reference section of this article; the qualitative interview data that support the findings of this study are available from the corresponding author upon reasonable request.

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How to cite this article: Porter, T., Watson, N., & Pearson, C. (2023). Epistemic sabotage: The production and disqualification of evidence in disability benefit claims. *Sociology of Health & Illness*, 45(6), 1164–1186. <https://doi.org/10.1111/1467-9566.13593>