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EXAMINING THE EXAMINING PHYSICIAN

Christopher R Brigham, MD

DR. BOREN: Thank you very much, Joan. Our last speaker is Dr. Christopher Brigham who is from Maine. He went to medical school at Washington University, and earned his master's from Rutgers. He's done a lot of things. He is the founder of Occupational Health Education, medical director of Occupational Health Resources, is in charge of the division of occupation medicine for the medical department of family practice at the Maine Medical Center, is a member of our organization, is involved with the certification of physicians for the evaluation of disabilities. And he's also board certified in family practice.

DR. BRIGHAM: Thank you. It's really a pleasure to be here today. I was pondering the fact that there are two other people who came from Maine today. Paul Bell who is here and Bob McAfee from this morning. How many of you have been up to Maine? A good number. Do any of you recall the sign as you enter Maine? There's a sign that greets you. Anyone? Don't be shy. What it says is "The way life should be." What we're going to talk about in the next 45 minutes is areas of disability, evaluation, management, the role of physicians, healthcare providers in that realm and clearly where we are right now is not the way that life should be.

We find that the costs, financial costs, the human costs, as discussed earlier today are tremendous. Over the years of being involved in this arena, like many of you I was a real doctor once and was in practice and then made a transition into occupational medicine and was really challenged by why people did not get well when they had disabling conditions.

I really came to appreciate the complexity, as I'm sure you appreciate the complexity, that the issues of disability are more related to perceptions and motivation, how that person, the contacts, family, society, employer in individual medical situations.

I was also struck by the fact that seeing people in evaluation – and I have seen in terms of chronic pain evaluations, over 5,000 people and I wish that on no one. I see people who have complained of back pain, have many subjective complaints yet cannot find anything objective, yet perceive themselves as disabled. Then doing some work in terms of training in the area of the ADA and really working with other people with types of disabilities who have profound functional limitations, profound impairments who were actively participating in society.

Why do we have this paradox? What drives this paradox? In recognizing the richness of the whole issue of disability, the complexity of the system, all the participants and also coming to the recognition that many of the problems that we have in the area of disability is due to our lack of ability as a healthcare system, that much the disability we create is iatrogenic.

So what I'd like to do with you in the next 45 minutes is to really examine that area. We'll go through and identify some of the challenges of healthcare providers, look at that in the context of presentation about the examining physicians. What is that role? What are the challenges of IMEs, of evaluators?

I have become as skeptical with IME's and evaluators as I have with physicians. To look at how do we define the characteristics of a quality evaluation and define a process to identify an appropriate evaluator, identify ways to maximize the value of an evaluation, look at some benefits of credentialing evaluators and really looking at the future of where we're going to be. Then I'm going to leave you with a charge.

How many of you share perspective or you can challenge that perspective, that much of the disability we see is at least in some way iatrogenic? What I want to do is when we look at the area of disability and how we approach that, we could look at the role of the family, the role of the employer, the role of attorneys. That would be fun, especially at the end of the afternoon. But what I wanted to do is really look at the role of healthcare providers because we're physicians, we're doctors and look really closely at our own area and look at where you, as insurance medical directors, can have some influence.

The thing I have been struck with is the failure in a number of areas. At the same time we can reverse this. Whenever we have a failure, that by identifying where the failure is, we can turn that around to what we need to do. And what you need to do in general, in terms of the medical community is in specific cases.

One of the things that over and over again I see is the failure to really assess, to differentiate issues of pain, pathology, impairment, functional limitations, disability. I don't need to discuss that with you, that's what you do.

Yet so many physicians get very confused by that. Many people get confused by that. Patients say, I can't work, how can I only

have an impairment of five percent whole person? Those are different concepts, that having pain does not necessarily mean that you don't function.

I had my own experience of a disabling condition. This was work related. About two years ago I was running out to the car, there was ice on the ground and I slipped on the ice, fell down, experienced pain on a scale of ten, it was a ten. I fell down and had a lot of pain in my upper back, went over and got some films done, cursed as I saw I had a scapular fraction and a T-9 compression fracture.

At that point, went and saw an orthopedic friend of mine and was given a sling. Do you know how long I was out of work with that? One hour. Because with that issue, that I indeed had a lot of impairment and functional limitations, but I returned to work.

Why did I return to work? Because that's what I love doing. I had responsibilities, this office with all the staff. And two other points that was mentioned in sharing this with the previous people was that I probably don't do much and second, there's clearly reflected some very significant underlying personality disorder.

Actually two days later I saw someone who was out of work for two years because over a period of one week there was a breeze on that person's scapula, upper back and that resulted in such severe pain that they needed to see a chiropractor five times a week and could not work. There are all these paradoxes we see. But there's a failure to asses the issues of pain, pathology, impairment, functional limitations, disability.

I think one of the big problems is a failure to really focus on ability and potential, that so often what treating physicians focus on and many evaluating physicians focus on is what people cannot do. We develop all these self-fulfilling prophesies. You can't do that, so that becomes what you can't do rather than what we can do.

If we look at the definitions, like the World Heath Organization definition of health which is a very expansive definition of health and sometimes a little bit fearful, because when we talk about benefits, how wide do we want to have that present there. We've got to recognize that when we're dealing with somebody whose disabled – reference was made to back injuries before.

What are the predictors of somebody returning to work? Are the predictors physical issues, extended impairment, what's on the MRI, or are the predictors job dissatisfaction, relationship to supervisor, recent performance reviews, involvement of attorneys?

There are other issues going on that we need to recognize and we need to manage. We really have to look beyond what's happening at the L-4, L-5 space level to what's going on with that person. As treating physicians make sure that they are working in a way to facilitate that person's functional restoration rather than reinforcing pain or pathology which may or may not have a significance or focusing on issues of impairment.

Some of the other failures of healthcare providers and these are helpful to understand because I think these are the same failures we see when we look at examiners. I think there's a failure to understand disability systems, insurance systems, legal systems, what definitions are that you have of disability. There's a failure to cooperate and communicate, participate as a team member. Maybe that relates to some of our experiences.

Perhaps there are sometimes even issues with physician's egos. I think there is also a failure with individuals to really make people responsible for their own health, well being, recovery process. So often I've seen people who end up giving up responsibility to someone who is treating them in a passive way, coming to see me and I do an adjustment three times a week.

What does that do to me? It reinforces that I have something wrong and somebody else is responsible for that. I think also the failure to use illness or injury as a teachful moment. What I mean by that is that you looked at some very skilled physicians, that someone comes in – do you have a back injury? Why did that occur? Not only from the work place, but how am I going to focus on your abilities so that it doesn't occur again, but how am I going to identify other risk factors, maybe fitness factors, maybe lifestyle choices? We don't do that and we need to do that.

In the previous presentation there was some discussion of some failure to develop goals, plans, time frames. In case management that's critical. When you review a case of somebody whose been defined as disabled, that treating doctor has specific goals, plans, time frames, how often does that occur? Very frequently? Pretty rarely.

Let's look from a different perspective, in the insurance companies, can you imagine having an operation where you didn't have some goals, some time frames, times when you re-assess things, look at where you're going. Why don't we do that with something so vital as a person?

We fail to utilize clinical and disability duration guidelines. That's a whole other discussion about the pros and cons and the difficulties in developing guidelines. But its at least giving us a frame work we can go and assess at this point in time, where are we, where should we be, what should we be doing. A failure to clarify history. In reviewing these thousands of reports, I repeatedly see failure to get adequate history particularly those behavioral, psycho-social, occupational issues. My role as a consultant is reviewing reports of other physicians involved in care. So often that critical information is really lacking.

And then a lack of recognition to behavioral problems. Is somebody with chronic back pain really looking at those behavioral problems? What you would expect, is any good physician treating that person, would identify issues such as symptom magnification which I find in most cases of chronic pain. On the other hand, I don't see many cases of true malingering. Symptom magnification indeed is very common. Issues with job dissatisfaction, issues with secondary gain, to be aware of those issues.

Other failures, or perhaps we should turn this around so we're not totally depressed by this evening, to where we need to be going in the future. That is utilizing diagnostic studies. So many cases I see when somebody perceives themselves as disabled, they've had multiple diagnostic studies done.

You still have pain, so you come back to see me. We've had a CAT scan so I'm going to do an MRI scan. We need to do another MRI scan. It shows some bulging. What does that mean to you as a patient? It means I must have something awfully bad for the doctor to keep on doing these things. There's a financial cost to those studies but I think there's a much greater cost in terms of what people's perceptions are about their condition.

The other area of looking over these cases is so often inappropriate care, not structured, not well defined. The most common problem I see is over-utilization of passive modalities, whether that can be adjustments or passive physical therapy, on and on and on. Not of much gain, at least to the person in terms of recovery, maybe to some financial gain to those people who are providing those services.

Or surgery done when there's not really indications to do surgery. We can't accept that anymore. We don't see, as often as we should see, a functional restoration approach. One of my biases is that where we've been in the past, that as physicians – I recall when I was in practice, too. I had people return to work and they got well. What it should be is people return to work *to* get well, that work itself is therapeutic. So we also deal with the issue of physicians needing to and not recognizing the issues of reasonable accommodation and direct threat.

Most physicians that I talk to are still very naive about the ADA. You get the first point – now at least some of them recognize that you're not talking about the American Dental Association. But when you go through title one issues and that whole process of defining reasonable accommodation or direct threat or if I'm looking at a case of worker's compensation and somebody says that that person is totally disabled, when you look in scrutiny to the ADA and direct threat of the whole issue of direct threat and substantial risk and immediate risk and the extent of that risk, there are very few times when somebody really is total disabled.

In fact, I'm sure you're aware of it, but there have been some suits now against physicians who have gone through and have defined people as totally disabled, that I go through and I define you as totally disabled, what does that imply? That means that I understood the possibilities of reasonable accommodation. I've defined, through a process of direct threat analysis, that you can't carry out these activities. Very rarely am I going to be able to support that. What have I done? I violated your civil rights. You can sue me for violation of your civil rights. Is my malpractice going to cover me? No. So hopefully this will change some behaviors. I support those types of changes and behaviors for our colleagues. We need to make them more accountable. We mentioned a failure to utilize early return to work, which is one of the most important tools.

In the previous presentation reference was also made to the area of health outcomes. We really don't assess health outcomes. We don't have good outcome predictors or parameters for that.

We look at some other tools, like corporate consulting. We've used total quality approaches to analyzing issues. We don't often apply those other areas of disability, evaluation and management. We should. I think the bottom line, looking at the standpoint of the treating physicians, is that unfortunately the conclusion I have is too much disability is iatrogenic.

We don't have any more low back pain in our society now than we did 50 years ago. We've got a lot more low back disability in our society than we had before and a lot more disability from other conditions. The earlier presentation this morning dealing with cardiac situations, about the lack of correlation about what's really there physically, objectively and the issues of disability. For us to tolerate that is being grossly irresponsible.

So what do we do about that? Well, one of the charges that Bill gave me was to discuss the area of IMEs and process of examining examiners. I think that's one way we can do that. I wanted to give you a backdrop of some of the problems I see with healthcare providers because I think many also apply to examiners. So when we go through them and we have a case to verify some issues on, that we're aware of the universe of difficulties that may be there, that we don't fall in the same trap with examiners.

My definition I use for an IME is an evaluation performed by a physician not involved in the care of that patient, that examinee, to clarify clinical and case issues, to address issues that have been unanswered or in conflict and to use that to assist in your case management or benefits administration or in litigation.

One of the things that, as a treating physician or most physicians, have not had experience in trying to clarify and answer some of the issues that need to be answered with a case. Some of the most common issues, we're pretty adept to find and diagnose, but I would challenge that we're not pretty adept though at looking at it from a standpoint of the other behavioral issues that are going on with chronic pain.

But how experienced are most physicians in the area of causation analysis, defining differences between exacerbations and aggravations or determining MMI or doing impairment rating? How many of you in medical school, or otherwise had formal training in terms of the area of impairment assessment?

We don't have that experience, then we're put out in the real world and called upon to have that experience. So we go through trying to address these issues and often don't have that information available in the record we're reviewing and we need to request an evaluation. Well, what's the problem?

Well, I think the problem is that evaluations are often inadequate. I think they're often unskilled and biased and not appropriately utilized. If somebody's being assessed with back pain, you can't

do an adequate assessment in ten or 15 minutes. In the IME arena it seemed to be that's where all the arthritic orthopedic surgeons went, and the blind radiologists, and everybody else that was sort of at the different point in their careers and said I'll do IMEs. Whereas I think you need to have those people that have the sharpest skills being involved in doing the evaluations. I saw some heads nodding on that perspective.

If we're going to go through and then get an evaluation done, I think we need to recognize some of the downsides of evaluations and use that as a perspective in terms of what we need to look for in terms of a solid evaluation.

I think what needs to occur, from my perspective – these are all my biases as I talk about this unbiased area – is that physicians involved in doing IMEs need to demonstrate knowledge and skills to differentiate things such as pathology and impairment and function and disability, whether it's a chronic pain issue or whether it's a cardiac issue, whether it's a mental/nervous case.

It must absolutely be impartial. I feel very strongly about that. Many states where there's always two sides, you always get the insurance impartial and you get the plaintiff impartial, that's nuts. You should be truly impartial regardless of who pays the bill.

Yet we've all seen people who have been biased one way or the other. I saw one report where the doctor sent in the report to the client. This was when I was a broker at an IME company about eight years ago. It had six different endings that they could choose. What's that?

I think the evaluations need to document an adequate history, especially the behavioral, the psycho-social, occupational issues. I think the physical exams need to document not only the positive findings but the negative findings, the non-physiologic findings. If you're reading a report and it says – this is somebody with back pain – that that person has tenderness in the back and can only bend forward 30 degrees, what does that tell you?

Well, it may be consistent with somebody with true problems. You can never prove or disprove pain. But somebody that has significant problems with their back and perhaps a more thorough report would say that those were reproducible range of motion measurements consistent with straight leg raising and the like, or that could be somebody who is controlling the behavior, then you put them to sitting and do a sitting straight leg raising which is 90 degrees or gets up to 90 degrees, that there's no correlation between the range of motion measurements with that, that you go through and do findings and there are multiple non-physiologic findings.

When we look at a report it really needs to document not only the positive findings but the negative findings and the non-physiologic findings, the behavioral findings.

The evaluations need to review all probative information. From my perspective, one of the most valuable things I found years ago adding to my assessments were pain and behavioral inventories, pain drawings, the pain disability index, the pain questionnaire, the multi-dimensional pain inventory.

It is very helpful to understand some of the other aspects of what's going on with that person. Then to do that from a multiaxial perspective, particularly if you're dealing with issues that have a behavioral overlay, really to understand what's occurring there so that person can be effectively managed.

For me it was involving systems to assure consistency in approach. So we use questionnaires and structured workbooks for physicians so that things are reproducible, so there's less variance in terms of the result than what occurs otherwise.

Then I think some of the other areas of need or failures right now is synthesizing all the data, formulating conclusions, having a clear, organized, detailed report, not a brief report. The other report I hate, the IME report, the ten pages long that's rambling, that's sort of no organization and you sort of try to identify where the information is. But something that's clear, organized, supportable in response to the client's issues.

So what are the characteristics, given those challenges and those needs of a quality evaluation? What do I think as an evaluator, as a consultant that you're looking for? You're looking for an evaluation that provides appropriate, comprehensive and organized information that better helps you understand what's occurring with that case, addresses specific issues.

It has supportable and impartial conclusions and performed in a timely manner at a reasonable fee. Do you agree with that? Do you disagree with that? How do we go through and do that? How do we maximize the value of an IME? How do we get to that point? Let me share with you some thoughts.

One, in terms of maximizing the value of an IME, you need to first identify the needs and specific issues to be addressed. If you're going through a case, consulting for a case manager, a claims adjuster about that or developing policies in your organization, you need to decide when do you get the IME and for what reasons.

Then to go through and to be really specific in the letter of referral for that and also in terms of who you select as the evaluator. For back pain, from my perspective, is that most evaluations of people with back disability are better done by physical medicine, psychiatrists or occupational medicine physicians who also have a good strong skill set clinically, or sometimes neurologists, than it is to have that done by a neurosurgeon or an orthopedic surgeon. You need to prepare and provide all available information.

Most times when I have an IME done, I miss a significant amount of medical information that would be really helpful in understanding what occurred. You want to provide that. You want to prepare a good referral letter and sometimes, if appropriate,

contact in advance. I welcome that. Somebody calling up and saying, you're going to be seeing this person, do you have a few minutes, can we discuss some details with you? Then analyzing the report and obtaining clarification if needed of any areas that are a little bit unclear.

Then I think the last one is evaluating that evaluator against standards and tracking performance. But track the evaluator, the quality of how they did with that evaluation because that may be helpful in the future to identify those people who are very skilled in this arena and those who are not. To really go through and assess a situation, it's really good to have something, some standards you can compare that against and use that internally in your process.

We mentioned selecting the appropriate physician. How do you do that? Well, select the appropriate specialty. From my perspective that's done by evaluating the experience of that physician. Now, that may be from your previous experience in working with that doctor or recommendations of others.

You can review their professional background, current activities. It's preferred to have someone who is still actively involved in the clinical arena. You may want to determine affiliations with professional organizations, determine their training that they may have had in impairment and disability evaluation. I find that in terms of professional affiliations, you may have physicians that are members of certain organizations that are involved in the disability evaluation arena. If this person has a special interest it is by far no guarantee that there's any specific skill set, unfortunately. But it's at least one differentiator.

Other ways you can go through is to use networks of physicians or IME brokers. There are a number of brokerages for IMEs. I really look at what those brokers do other than assisting you and arranging to get an appointment. My experience, being involved in the industry in the past, was there's not much value added other than the convenience of doing the scheduling and getting the report processed.

In the past, I know some of the philosophies were you try to negotiate how you can bill as much as possible to the client and pay the doctor as little as possible. So really look at what's going on and I'm sure that there may be some very quality networks and brokers out there but look at them very carefully.

Then the other part in selection is you can look at screening the potential evaluators, examining. If I have a case that I'm evaluating and I really need to get an IME done, I'm not going to do this in a casual way. I'm going to make sure that that report is really of substantive value to me.

So I may go through and speak with that physician, I may examine example reports, just a couple reports. I may review his or her curriculum vitae. But that does not necessarily mean that they have the skill set that you need.

I may want to interview them. What's their perspective? How do they do the assessment? Maybe get an idea of what their experience is in the area of testimony. Then obtaining recommendations from others.

With these challenges and with my difficulties and being appalled by – there's enough to be appalled by some of the lack of skills of my colleagues – treating physicians but then you look at the area of who are IME physicians who should be of a different caliber. I was hoping once that it would be a higher caliber. But being appalled by really not doing what we are charged to. Look at how do we go through to really change that. So one activity that's occurring is the process of credentialing evaluators. This year the American Board of Independent Medical Examiners was incorporated. It's a non-profit Washington, DC based organization which is planning the first certification exam for independent medical examiners in mid-1995.

This whole process for me in working and consulting in that arena has been exceedingly challenging, probably the only experience in the Board of Insurance Medicine. How do we define standards? How do we go through an analysis of the task that an IME physician does? What's the knowledge and skills necessary? What's the role delineation? How do we validate that role?

Once we've done that, how do we go through and develop the certification examination? You take the role delineation and then develop test specifications, item development and then examination content is constructed with content specialists and development experts and the scoring, a very complex task.

Let me just leave with you a couple things. When I look at the future of IMEs, being very involved in this arena, I think that one, it's become clear to me that there's going to be a need on an ongoing basis for impartial evaluators. I wish we were at a point where we did not need to get another layer of people involved, that treating physicians could answer questions in an impartial way. I don't see that occurring. I see an ongoing need for that.

I see a further emphasis on quality, comprehensive evaluations. I see further training in the area of pain, impairment and disability assessment. I see that both in terms of various course opportunities, other alternative media. There's been some video tape development in this area. I see the need for the establishment of standards for the evaluations, for the evaluators and for treating physicians. I'm sure that there will be credentially of independent medical examiners and there will be developments of networks of skilled evaluators.

More important than anything in terms of the specifics of looking at the challenges with treating physicians, with the issues with examiners or how to select that, I think coming back to some of the issues that we started with, I really want to leave you with a charge. What I really want to do is charge you, that this group, you're in leadership positions in insurance medicine, that I really charge you, encourage you not to accept disability as it has been. The human, the financial costs, you're all aware

are too severe. No question we're wasting tremendous human potential and through that loss of human potential, really bankrupting who we are as a society.

What I suggest, encourage, is that each of you vision the way life should be and maintain a clear focus on ability, on potential and on the therapeutic value of work and that you take those philosophies, the approaches and hold everybody, including claimants, doctors, healthcare providers, lawyers, insurers, accountable so that we get away and no longer have what we have, that we disable this whole process of disability. Thank you.

(Applause.)

DR. BOREN: Thank you very much. Dr. Baker would like to address us just before we leave. Are there any questions?

AUDIENCE MEMBER: Coming from England, congratulations on a very interesting paper. I would like to just add a comment really, that in England we get very good independent medical examinations for insurance purposes. Our great problem, however, is translating those recommendations that the independent medical examiner has to the actual physician in charge of the patient and often you find that people with, say, back pain have a mild depression, they have other related disorders, none of which are addressed and it is these factors that actually cause a patient to be off work longer than they need to.

DR. BRIGHAM: I think that's a good point that I find in my own experience. We routinely use with people with back pain depressive inventories and more often than not, at least there's some mild depression which one would expect as part of chronic pain with that.

It really becomes how do you get that information to the treating physician and then how is that used. That's more of a difficult systems issue. Let me tell you how we've dealt with this with our clients in our practice. We do about 100 IME's per month. We routinely – this is with the client's blessing – we directly send a copy of our report always, with a signed release of the patient, to the treating doctor. We found that actually many treating physicians appreciate that, from others we get letters back that are not quite as appreciative. But it helps.

AUDIENCE MEMBER: In the role of claims adjudication and I do a lot of independent medical exams and I do adjudicate claims, I believe that the medical directors have fallen down because I believe that a lot of the claim is dependent upon the claimant and his relationship with his attending physician. And there's a real bond there and that bond needs to be broken a little bit usually by a doctor at an insurance company. I don't think it's sufficient to expect a claims adjudicator to attempt to come between a claimant and his attending physician, but it takes a doctor to come between that relationship.

It's fine to say we'll get an IME but on the one hand, you've got the IME and on the other hand, you've got an attending physician and I think it's going to lead to ongoing controversy unless you get the attending physician on side and it's better to do it before you have to resort to an IME.

DR. BRIGHAM: I agree with you strongly. I think many times I've seen what would appear to be co-dependent relationships between the claimant and the treating doctor that are difficult to modify and more likely to be modified by another physician's involvement, by calling up in advance and saying we need to clarify what's going on with this patient.

You establish some rapport. He's going to go through the issues of working with their egos, to separate things. If you say we're going to go ahead and do the evaluation and you get the buy-in with that physician and would they consider the results of that, you're going to be far more successful.

One of the problems I have with many IMEs is that they just document activity on a file without really being used in the context of when do we strategically use it and how do we use that information, which is something we can do in advance to maximize the benefit of the evaluation. Good comment. Thank you.

(Applause.)

DR. BAKER: Thank you, Chris. I think we have seen an intertwining and a running in parallel of speakers this afternoon. Somehow they have all managed to cross their lines and give us added information on each topic.

(Meeting recessed.)