Series 4: Pain as a Disability

ABSTRACT: *In the following Series of articles, you will learn: [1] how chronic pain need not be a disability; [2] ideas for employers to control specific issues of back problems and that the well-managed concept includes the idea that any company that does not have a structured Disability Management/Return-to-Work Program cannot consider itself well managed; [3] strategies for independent medical examinations and the testimony of the examiner as well as its importance from the perspective of vocational experts, attorneys, a forensic psychologist, and a pain specialist; and [4] about the use of opioids for treating chronic pain and how it affects the workplace, as well as alternative methods of treatment and what employers can do regarding medication abuse.*

Pain as a Disability

by Jasen M. Walker, Ed.D., C.R.C., C.C.M.

Part 1

Introduction

Pain is a complex human experience that is seldom completely understood, and too frequently a problem for not only patients and their physicians, but work organizations that wish to keep employees productive. Pain is a mental event that cannot be appreciated solely in terms of tissue damage. Chronic pain, pain that continues for more than three months, is one of the most serious international health care problems, and it has enormous economic consequences.

It has been estimated that one-third of the American population experiences chronic pain. Musculoskeletal conditions, such as low-back pain, joint pain, arthritis, and rheumatism, are the leading causes of disability in people during their working years. Complaints of back pain are second only to upper respiratory conditions in accounting for work absenteeism. Pain is undoubtedly a major contributor to the cost of disability, which has been estimated as approximately eight percent of payroll for the average American company.

Pain is the most common presenting complaint seen by physicians. Pain behavior in the presence of a physician is a very important form of social communication, one that may intend to invite the physician's declaration of total disability.

Nonetheless, is pain inevitably a disability that requires time off from work? As a clinical manifestation, pain, particularly chronic pain, is often elusive, intractable, and inextricably intertwined with social, psychological, cultural, and economic factors. As a problem potentially reducing occupational capability and productivity, pain is difficult to assess in an efficient, fair, and reliable manner. Pain is inherently subjective; there are no thoroughly reliable ways to assess it; and the correlation between the pain experience and occupational disability is a substantial measurement challenge to all professionals who are charged with the responsibility of assisting people back to work.

Work disability can be thought of as the inability to perform the essential functions of a job in multiple ways, including the job's mental, emotional, and/or physical demands. The Commission on Rehabilitation Counselor Certification (CRCC) notes in their *Code of Professional Ethics for Rehabilitation Counselors* (Code A.1.c.) that Rehabilition Counselors "work with clients to consider employment consistent with [the client's] overall abilities, functional capabilities and limitations" along with other factors to assist in finding appropriate work placement. Chronic pain can certainly cause functional limtiations, and therefore must be considered in assessments for return to work. In this article, we will address how the rehabilitation professional can help to determine if an individual's chronic pain experience causes disability from work. Therefore, functional, multifactorial assessments of pain are required in determining if pain truly causes vocational disability.

Defining Pain

Stedman's Medical Dictionary (26th Edition, 1995) defines pain as "an unpleasant sensation associated with actual or potential tissue damage, and mediated by specific nerve fibers to the brain where its conscious appreciation may be modified by various factors." Acute pain is pain for which there is a readily available biological explanation. Acute pain is associated with trauma, illness, or disease. To the extent that there is an emotion associated with acute pain, it is usually anxiety. Acute pain should be treated aggressively by health care providers, and there is no contraindication to using narcotic analgesics for pain relief. Chronic pain continues long after the biological explanation is over. Chronic pain remains after tissue damage should have healed and is frequently associated with depression and helplessness. Chronic pain probably should not be treated with narcotic analgesics and frequently must be managed because it is not amenable to relief with purely medical interventions. Moreover, individuals should be encouraged to deal with their chronic pain and to remain productive.

Thus, pain lasting longer than the time expected for biological healing is a mental event that cannot be understood solely in terms of tissue damage. Pain is a perception, an experience, and the continuation of pain perception with associated thoughts and emotions once tissues have healed can be thought of as pain behavior. In *Behavioral Methods for Chronic Pain and Illness*, Fordyce (1976) has shown how pain behavior can be modified in clinical rehabilitation settings. Fortunately, the vast majority of individuals who sustain painful injuries recover spontaneously within a matter of weeks or months. For too many individuals, however, the onset of pain, whether traumatic or insidious, marks the beginning of a slow but steady dissent into total and permanent vocational disability.

Pain, however, need not become disability. The longer pain lasts, the greater its intensity, the more it, as a balance, is allowed to impact the psychosocial aspects of living, to influence or manipulate others for example, and the more it can become vocationally disabling. However, occupational disability need not be the inevitable result of chronic pain. One way of understanding pain in the contexts of time, intensity, and functionality is to fully appreciate the difference between medical impairment and occupational disability.

Medical Impairment and Vocational Disability

The American Medical Association draws a distinction between medical impairment and occupational disability. Medical impairment is a physical or mental defect at the level of a body system or organ. The official World Health Organization definition is "any loss or abnormality of psychological, physiological, or anatomical structure or function." Simply speaking, impairment is what is wrong with the individual.

Occupational disability, however, is any restriction or lack of ability to perform an occupational activity in a manner that is expected. The term disability reflects the consequences of impairment in terms of an individual's functional performance and activity in a social context. Occupational disability relates to work exclusive of the social consequences of impairment, and vocational disability can be mitigated or fully eliminated by modifying employee behavior and/or employer prejudices.

Job accommodations in many instances have been found to not only enhance the productivity of people with impairments, but make work safer and more predictable for employees without medical impairments. For example, industrial lift equipment alone has made it possible for all people with limited physical strength to increase their work capacities.

With regard to pain, it need not be a disability. Individuals in chronic pain can work if they are willing to do so and accommodated at work with manageable tasks. Frequently, however, chronic pain is mismanaged by the patient, health care provider, and employer, so that eventually the chronic pain sufferer no longer has the will to work. In this case, the difference between ability and will is critical. Time out of work is inevitably a key factor. For years, it has been known that only 50 percent of individuals with low-back pain who are out of work for six months return to gainful activity. After 12 months of lost time, the return-to-work percentage drops to only 20 out of 100.

Obviously, early intervention is key. However, the rehabilitation professional charged with the responsibility of assessing vocational disability and residual employability must be prepared to evaluate the capacity to work at any time following the onset of a painful injury or disease. In a vocational rehabilitation evaluation, the ability to work with pain can be addressed by measuring the key traits that are most often affected by the pain experience. These traits include physical capacities, mental capabilities, and emotional status.

Measuring Work Ability

Pain can affect cognitive ability, temperament, and physical capability. Individuals in acute pain can potentially perform in ways that would suggest that the pain actually enhances each of these domains. For example, people in crisis situations, such as a burning building, often respond cognitively, emotionally, and physically in ways that surprise them retrospectively. Science has shown that this is probably the result of adrenaline surging through the body. However, when the adrenaline rush is over, tissue pain can be debilitating. Once the tissue is afforded the opportunity to heal, one would expect the pain to end. Unfortunately, that has not proven to be the case, and injured or ill individuals can experience so-called chronic pain.

Chronic pain may be thought of as a psycho-physiologic impairment, but it need not be an occupational disability. Like acute pain, chronic pain (pain lasting more than three months) can affect occupationally relevant characteristics such as cognitive ability, temperament, and physical capability. Indeed, one might claim to be in chronic, intractable, disabling pain, but that person's capacity to function or work is measurable beyond subjective complaint alone. Standardized measures of cognitive (mental) ability, temperament, and physical strength can greatly assist those concerned with the occupational consequences of chronic pain.

Assessing Pain's Effect on Mental Ability

Individuals in chronic pain frequently report that they cannot think, concentrate, problem-solve, and otherwise work as efficiently as they did before the onset of their pain. People who report that chronic pain disables them occupationally often declare that they have trouble functioning cognitively as they did previously.

Despite an individual's report of pain, he or she can nearly always be tested with standardized measures of academic achievement, vocational aptitude, and intelligence. If the individual scores well (or as expected given his or her pre-morbid background), can we logically conclude that the pain is disabling in terms of negating cognitive ability? For example, the *Working Memory Index (WMI)* of the *Wechsler Adult Intelligence Scale-IV* provides reliable information on how well an individual can attend to and concentrate on orally presented information (i.e. solving problems without the benefit of paper and pencil). Utilized in a battery of other tests measuring cognitive capability, the *WMI* can offer the vocational evaluator specific information about how the rehabilitation client functions with regard to attending, concentrating, and freeing oneself from distraction.

Thoughts, beliefs, attitudes, and self-expectations are all examples of cognition that can be assessed in relation to pain. Objective personality testing, however, can yield much more reliable data regarding how pain may be affecting an individual's temperament and work personality.

Measuring Temperament

Affective assessment of those who are thought of as vocationally disabled secondary to chronic pain is important because people reporting chronic pain frequently describe depression and anxiety. Moreover, nearly all workers must relate to others in some fashion while at work. Emotional deficits can interfere with an employee's interpersonal communications. Interactions with people at work can vary from highly demanding and refined mentoring and negotiating to simply speaking and/or signaling to others to carry out job functions.

Objective personality testing is available through a variety of measures, from the very detailed *Minnesota Multiphasic Personality Inventory-2* to the *16 Personality Factor Questionnaire*, both of which include validity checks to determine how genuine the examinee was in responding to test items. In terms of assessing an individual's psychodynamics after the development of chronic pain, objective personality testing can provide valuable information as to how pain perception and perhaps illness behavior potentially affect the rehabilitation client's capacities to interact with others in the workplace.

Measuring Physical Capacity

Chronic pain may be disabling if it negates or diminishes an individual's capacities to sit, stand, walk, lift, carry, bend, and otherwise perform physical work. The Functional Capacity Evaluation (FCE) is a specialized form of

assessment that is usually performed with biomechanical hardware and by a certified assessment specialist, usually a physical therapist. The FCE is performed to quantify functional capabilities and limitations for physical work. When the FCE shows that the essential physical abilities are present to match a job description, then the individual with chronic pain, despite his/her complaints, can meet the exertional demands of a particular vocation.

Sometimes, of course, chronic pain can affect work tolerance or endurance, and the FCE becomes the best available evaluation to indicate whether work hardening is necessary and appropriate. In addition to showing deficiencies of physical ability, a good FCE will show the physical reasons for those deficiencies, and those physical reasons may very well be addressed in work hardening and/or by job accommodation. For example, if a person with chronic back pain cannot sit or stand for prolonged periods, then the job accommodation of allowing the person to change his/her posture to find comfort may very well be considered reasonable depending on the job and the employer.

Symptom Magnification and Observation

None of the assessment tools mentioned above are more important than the qualitative data that employment of these methods can supply to the trained observer. According to Matheson (1982), symptom magnification is a complex pain behavior that involves a "constellation of reports or displays of symptoms which functions to control the environment," usually in a manipulative or maladaptive manner. However, as with any human behavior, pain behavior is meaningful and purposeful. Therefore, a trained observer must be present and willing to look for consistencies and inconsistencies in what a person reports or displays, and how the individual actually functions in relation to measures of mental ability, temperament, and physical capacity. Otherwise, the symptom magnifier will display symptoms (real or imaginary) in an effort to secure social reinforcement, generally by manipulating his or her performance.

In the evaluation context, those reported symptoms can be misleading without the observer recognizing that critical behaviors must also be measured and evaluated concurrently. Thus, one might find the symptom magnifier actually performing a work-like task completely, while at the same moment complaining that he/she cannot do it.

Summary and Conclusion

Chronic pain (i.e. extended pain) is a serious health care problem. The estimate of the prevalence of chronic pain in the general population is that as many as one-third of all Americans experience it. When chronic pain is examined in the context of return-to-work programming, the cost factors to employers can be substantial if not addressed knowledgeably.

What vocational rehabilitation professionals – working from medical research models – have found is that chronic pain need not be a work disability. Using FCE outcomes and the results of standardized instruments, experienced Vocational Counselors are competent to overcome the return-to-work obstacles that chronic pain often presents. The methods of rehabilitation appropriate for employees manifesting chronic pain symptoms are "job accommodation" and "transition-to-work programs."

Part 2: Issues

A Definition of Chronic Pain

This article focuses on the concerns of chronic pain and Transition-to-Work programming. The working definition of chronic pain that CEC Associates used in preparation of this article is:

> *Chronic pain is pain that persists after adequate medical treatment has been administered, traditional medical treatments have been exhausted, and a normal period of time has passed during which a cure or healing might have been expected.*

Returning to Work with Pain

Returning employees to work after an injury or illness is a process in which most employers have experience. Frequently, the return occurs before complete recovery has occurred, but the prognosis is for eventual near-total recovery.

When the return to full employment is complicated by continuing pain (real or perceived), the solution is compounded. That is, a return to work is not absolutely contingent on the employee being pain free, either at the time of the return or in the future. The issue then becomes one of finding ways to accommodate the employee with continuing pain and keeping him/her productive.

The single most important aspect of a return to work for all employees is that the return is developed as a transition. There are few, if any, cases (with pain or pain free) where an abrupt re-entry to work will be as successful as a planned, incremental return. In fact, the Certification of Disability Management Specialists Commission's *Code of Professional Conduct* includes in its definition of "disability management services": The prevention and minimization of the human and economic impact of illness and disability for the employee/employer to optimize the quality of care, productivity, organizational health, and regulatory compliance. The goal of disability management is to provide necessary services, using appropriate resources in order to promote the ill or injured individual's maximum recovery and function." The term used by rehabilitation professionals for this process is a Transition-to-Work (TTW) program.

In conjunction with disability management, case managers may be involved to provide client advocacy to the injured employee. According to the) *Code of Professional Conduct* of the Commission for Case Management Certification (CCMC), advocacy is defined as: "The act of recommending, pleading the cause of another; to speak or write in favor of."

The primary issue with pain is to determine whether it is an "impairment" or a "disability." If the pain is determined to be an impairment, then a decision may be made as to whether the pain will preclude the employee from performing tasks other than his/her pre-injury/illness work. For example, an employee whose pre-impairment assignment involved a physical activity (e.g., walking, standing, and lifting) that now cannot be achieved because of attendant pain might be assigned to a new work activity in which the specific physical activity that caused the pain has been reduced or eliminated. In this case, the impairment is "accommodated," and there is no absolute disability. One deemed disabled in a specific activity is not necessarily disabled in all other activities.

Medical experts are responsible for determining what physical (or psychological) impairments an individual may have. Such medical diagnoses are called "functional capacity evaluation" reports. Given the medical knowledge of the specific impairment, it then becomes the responsibility of the employer (through vocational rehabilitation professionals) to determine the level of disability of the individual. If, in fact, the impairment precludes the employee from doing any tasks in the work organization—with or without accommodation—then the employee may be determined to be disabled. If, on the other hand, the employee can be productive in a different work assignment, or the same assignment with appropriate accommodations, then the individual can be classified as not being disabled in all possible work assignments.

The most frequent causes of workplace injuries that result in post-treatment pain are:

- strain injuries (including Carpal Tunnel Syndrome),
- back injuries,
- soft-tissue inflammation, and
- musculoskeletal disorders.

Chronic and persistent pain may be the direct result of work-related injuries (or post-trauma or surgery complications), but they may also be the result of personal and psychological stressors, such as:

- personal financial pressures,
- family discord,
- depression, and
- sleep disorders.

Interventions

The most effective interventions are proactive. That is, employers need to develop strategies that will prevent and reduce injury/illness occurrences. The single most effective strategy is creating a Safety and Wellness (S/W) program. The function of an S/W program is to educate employees on ways to eliminate, or at least limit, accidents and avoidable illnesses. Work-risk analysis is the basis for determining the concepts to be inculcated. The safety aspects of this kind of program are closely tied to proven job redesign and ergonomic models.

When an individual identifies pain that persists after curative medical treatments, there are pain rehabilitation methods that can be applied. These include, especially:

- physical therapy,
- pain education and vocational counseling,
- stress management techniques, and
- exercise and fitness routines.

Since TTW programs are predicated on planning and incremental steps, this approach to return to work is ideal for managing pain. In a TTW program, on-the-job training is meshed with pain treatment in steps. Each day is divided between actual pain abatement training and work assignments that are incremental, from limited time on the work task to eventual integration into full-time work and the phasing out of training. Specific training on the non-work, pain-reduction aspects will include:

- physical conditioning (sometimes referred to as work hardening),
- education sessions,
- relaxation training,
- individual (and, if feasible, peer and group) counseling,
- support systems (e.g., personal, family, financial, and medical),
- delayed gratification acceptance, and
- progress analysis and rewards.

Traditional TTW programs are developed by a team of appropriate persons. At minimum, the team will include a medical professional (a physician or a Case Management Nurse) and the supervisor of the employee after he/she returns to work. Needless to say, the plan also requires the input and approval of the employee for whom the program is being designed. The TTW plan should also include projected milestones to evaluate the employee's progress and follow-up schedule, which could include visits to the medical professional assigned to the case.

Self-Management Treatments for Chronic Pain

The scientific and medical professions have, in the past several years, invigorated their interest in that part of patient care that focuses on pain relief. Two recent professional studies on pain, conducted under the auspices of the International Association for the Study of Pain,[1] relate to the responsibilities of Vocational Rehabilitation professionals. These findings are relevant to "pain as a disability" and "pain as an aspect of return to work."

One study suggests that an "increased commitment to a self-management approach to chronic pain may serve as a mediator or moderator of successful treatment." An instrument, *Pain Stages of Change Questionnaire (PSOCQ),* was developed to "assess readiness to adopt a self-management approach to chronic pain." That is, Vocational Rehabilitation Professionals may have a new tool to assist employees in returning to work and making the transition more smoothly.

A second study found that an original study done on animals is also true for humans. In that study, the researchers found that "fear inhibits pain" but "anxiety enhances pain." The ultimate value in vocational rehabilitation is in finding ways to identify and lessen the anxiety factors associated with a return to work.

The outcomes of both of these findings undoubtedly hold significance in vocational rehabilitation, and it will now be up to professional Vocational Experts to work out strategies to apply the findings.

Assessment of Pain and Pain Behavior[2]

Since pain is a perceptual event, it cannot be measured in terms of the presence or absence of tissue damage. Rather, evaluation must develop around knowledge of the kind of pain that is present.

Aspects of pain classification would include, but not be limited to the following:

- temporal variable (i.e. acute or chronic),
- location or system (i.e. headache or low back, muscular or neuropathic),
- age of the patient,
- presence or absence of malignancy,
- psychosocial pressures on the patient, and
- intensity of the pain.

To measure the intensity of pain, the professional could use one of the following methods:

- A numeric rating scale: on a range of 0 to 10, with 0 indicating no pain and 10 indicating the most intense pain.
- The McGill Pain Questionnaire (MPQ): the most widely used instrument for evaluating pain designed to capture subjective qualities with adjectives (e.g., tingling, itchy, smarting, and stinging).
- The Descriptor Differential Scale: 12 intensity descriptor items (e.g., faint, strong, slightly intense, and extremely intense) rated on a 21-point scale.

Physiological evaluations are used to examine the relationship between the behavior of the individual with pain and the physical responses that may accompany pain. The three most common forms of physiological assessment in chronic pain are:

- Myography: assessments of the muscles that frequently accompany pain in the form of muscular tension or spasms.
- Cardiovascular: recordings of heart rate, blood pressure, and skin temperature.
- Skin Conductance: measures changes in sweat gland activity.

Behavioral assessments may be defined as personal reactions to impairment. There are three approaches to behavioral assessment, ranging from direct behavior observations (generally of videotaped samples) to self-administered questionnaires. The direct observation method is preferable to a self-administered approach, but it also requires greater resources for the activity. Somewhere between the observation and the self-reported methods is the pain behavior checklist. The most widely used checklist is one developed by the University of Alabama-Birmingham called the Pain Behavior Scale (PBS). This checklist contains 10 pain behaviors (e.g., grimaces, downtime, and medication use) that are rated on a 3-point scale. Checklists come as either administered or self-administered instruments.

Another approach to pain evaluation is through cognitive and affective assessments. Thoughts, beliefs, attitudes, self-statements, and expectancies are all examples of cognition used to assess pain. The primary instruments used in this approach are:

- Coping: The Coping Strategies Questionnaire (CSQ) contains eight subscales of six items each. The objective is to measure diverse coping strategies, such as “diverting attention,” “catastrophizing,” “pain behaviors,” and “reinterpreting pain sensations.” The Vanderbilt Pain Management Inventory contains 18 items reflecting either passive (“restricting activity” or “depending on others”) or active (“engaging in physical exercise” or “distracting attention”) coping efforts.
- Beliefs and Attitudes: There are also instruments for measuring patient beliefs. Samples of these instruments include the Multidimensional Health Locus of Control Scale, the Cognitive Errors

Questionnaire, the Pain and Impairment Rating Scale, the Pain Related Control Scale, and the Pain Related Self-Statement Scale.
- Mood and Anxiety: There are no instruments designed specifically to measure the affective aspects of pain, but the Beck Depression Inventory (BDI) is a questionnaire frequently used to evaluate mood disturbances.

In addition to the specialized assessment instruments listed above, there are also "inventories" that can be used in the vocational rehabilitation process. For example, the two most used pain-specific inventories are:

- The Multidimensional Pain Inventory: a comprehensive instrument devised specifically for patients with chronic pain.
- The Psychosocial Pain Inventory (PPI): designed to elicit information about pain behavior and beliefs.

Most Vocational Counselors trained in assessment methods and materials are familiar with the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). This is the most prevalent standardized inventory used for evaluating patients with pain. Other psychological inventories include the Million Behavioral Health Inventory (MBHI) and the Million Clinical Multiaxial Inventory. These latter two inventories were standardized on a medical basis rather than on the mental health population of the MMPI-2.

Vocational Rehabilitation Professionals will need to recognize that pain is an impairment and, as such, can be managed in a way that will provide an opportunity for the employee to return to productivity. To succeed in returning injured workers to productivity, Vocational Counselors will need to be trained and certified in the methodologies and materials of vocational evaluation.

Tolerance for Pain

One of the most important studies on pain and disability was conducted by the Committee on Pain, Disability, and Chronic Illness Behavior at the Institute of Medicine. The study was published as *Pain and Disability: Clinical, Behavioral, and Public Policy Perspectives* in 1987 by the National Academy Press in Washington, D.C.

In a subsection titled *Medical Definitions Versus Functional Concept*, the study addresses the issue of tolerance for pain:

…there is substantial individual variation in terms of tolerance for pain… Many factors interact in complex ways to influence individual tolerance, motivation, and functional capacities such that some people are able to work in the face of severe symptoms and others are unable to work when confronted with less severe symptoms (pp. 69-70).

The reality of a disparity in tolerance levels creates a difficulty for employers trying to distinguish between those who will benefit from a Transition-to-Work (TTW) program and those who are truly incapacitated. Generally speaking, workers who can be engaged in TTW programs are more likely to have positive outcomes than those who resist the effort. At least three studies[3] indicate that employed patients have better treatment outcomes than unemployed workers.

Commitment to a Return-To-Work Program

Numerous studies show that companies interested in the cost effectiveness of their operating procedures will have a strong management commitment to a Return-to-Work program for employees who have suffered injury/illness. A certain and early return to work is one of the most successful strategies that employers can use to control their workers' compensation and other insurance costs. The commitment to return to work includes the following components:

1. Prevention

- Safety and Wellness Programs
- Safety and Wellness Committees
- Training Programs on Safety/Wellness

- Safety/Wellness Incentives
- Incident Investigation
- Injury/Illness Documentation and Database Maintenance
- Repetitive Trauma and Ergonomics

2. Transition-to-Work

- Management Commitment
- Program Design and Implementation

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A Pain in the Back

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Part 1

Introduction

The most frequent and costly cause of lost work time is, to no one's surprise, back problems. Back problems cost employers an estimated $75 billion per year in direct workers' compensation costs alone (Source: HR Magazine Online, 9/5/01). And, the real cost, the total cost, to employers is even higher. The cost of lost productivity due to back problems is even more than the total cost of workers' compensation for this specific problem.

Are there strategies and methods that employers might use to address the issue? This article will focus on some ideas for employers to control the reality of back problems.

As with any injury or illness leading to lost time at work, the key to ameliorating the high cost of back problems is prevention. There are two basic aspects of prevention that employers need to address:

- Creating and conducting safety and wellness programs, including exercise, weight loss, and stress-reduction sessions.
- Conducting ergonomic surveys of the workplace and redesigning work tasks to conform to the results of these surveys.

The single most effective strategy is to train and educate employees on prevention. Employers need trainers who have been trained to teach others how to avoid injuries and prevent illnesses, as well as how to prevent back problems specifically. In small companies, the trainers might be individuals assigned the responsibility as a supplement to their regular duties, or by contracting for outside trainers to do part-time training.

In larger companies, safety and wellness programs are essential. These programs need to be carefully structured and documented, facilitated by competent individuals, pressed to remain vital by achieving positive results, and continued over time by offering fresh issues to examine. In addition to general principles of health, wellness programs should especially include weight loss, stress reduction, smoking cessation, and nutrition.

It is also important to note that training need not be focused on the lowest level of employee. In fact, training supervisors will produce a higher return on investment than direct training of employees on the lowest level. Back problems, more than any other injuries with the exception of repetitive motion injuries, lend themselves to prevention and reduction through ergonomic redesign. (Back problems can, of course, result from tasks with high incidences of repetitive motion.) Engineers specifically trained in ergonomics and safety can make work-site adjustments that will return several times more in cost savings than the amount spent.

Another aspect of ergonomics is what is known in business management case studies as the "Hawthorne Effect." Named for an experiment more than 50 years ago in a manufacturing plant in Hawthorne, New Jersey, the "effect" is achieved when modifications that workers perceive to be to their benefit are made in the physical environment. That is, even if the ergonomic redesign does not in reality produce a desirable effect, if it is perceived to do so by the worker, the desired result will be realized.

After all the preventive measures have been implemented, the next most cost-efficient practice is a commitment to a return-to-work program. A return-to-work commitment manifests itself through a Disability Management (DM) program.

DM is an initiative designed to minimize the impact of disability (injury or disease) in the workplace. A good DM program is the outcome of a joint effort between management and the workforce. The objective of DM is an early return to work of employees. (Studies reported by the UNUM/Provident Corporation put cost reduction for all disabilities, when addressed through a Disability Management program in the workplace, at 20-30% over non-managed programs.)

Why is DM a desirable process? An employee's chance of successfully returning to productivity (and, thereby, to the continuation of a healthy and meaningful life with self-esteem) is highest if he/she does so soon after an injury occurs. There are significant cost savings and other considerable benefits to employers who offer DM programs. By conducting an aggressive DM program, companies gain the respect and loyalty of their employees, and employees who participate in good DM programming are even more highly valued and rewarded by their employers. In this effort, certified DM professionals can be of great service to employers and injured workers. Per the CDMSC *Code of Professional Conduct*, DM specialists' primary obligation is to "exercise independent judgment in offering appropriate recommendations that consider the client's needs and the parameters of the applicable disability management system." When involved, case managers are to "provide the necessary information to educate and empower clients to make informed decisions. At a minimum, Board-Certified Case Managers (CCMs) will provide information to clients about case management services, including a description of services, benefits, risks, alternatives and the right to refuse services," according to the CCMC *Code of Professional Conduct* (S9).

What are the critical components of a DM program? There are a number of components of DM, but the critical ones are having valid Job Descriptions and a Transition-to-Work (TTW) program in place.

Job analysis and job descriptions are based on the essential functions of a job. Job analysis is an exact science that occurs by applying objective measures: pounds to be lifted, frequency of stooping, length of time to stand, repetitive motions, environmental conditions, etc. Jobs need to be analyzed by a staff member trained in job analysis methods and materials. Job descriptions are based on the measurable outcomes of the job analysis, and they become the blueprint that can be modified when re-employing (returning) someone with medical restrictions. TTW programming is another essential aspect of DM. To return employees to work at the earliest possible moment, a TTW program has to be organized and implemented. The two basic concepts of TTW are:

- Employees are reintroduced to work in incremental steps.
- There are specific roles for staff and specific strategies to be used.

While DM programs are, of course, designed to work with all disabilities, they are especially effective with back problems. Back problems can be stated in terms of statistical realities. According to Stover Snook, Certified Professional Ergonomist and lecturer on ergonomics at the Harvard School of Public Health:

- 75 percent of people recover from acute low-back pain within two weeks.
- 90 percent recover within six weeks.

And, what is even more startling is that these percentages occur with or without treatment and regardless of the type of treatment.

Given these statistical realities, it is important that employers engage their employees with back problems at the time of the injury, that they keep in close communication with the employee, and that they effect an early return to work in a TTW program structured in incremental steps. By applying "best-practices" disability management, employers can make dramatic inroads into the intransigent nature of back problems in the workplace.

One aspect of good DM is case management. Someone in the company needs to be assigned the responsibility of working with the injured worker from the moment of the injury until a full return to work is accomplished. The immediate responsibility for this monitoring and support will be the injured worker's supervisor. In some cases, the monitoring/support function is turned over to a professional Case Manager.

Whoever is responsible, the objective is to complement the DM process, especially as that effort relates to the medical treatment plan. Other professionals who can play essential roles in support of the DM program are Vocational Counselors. Case Managers and Vocational Counselors are trained to work with employees who have back problems, and they have the experience to find the solutions necessary to control the back-problem aspect of returning to work.

In terms of the treatment plan prescribed for the employee with an injury resulting in a back problem, there are other professionals who may be vital to the solution. These professionals include Physical Therapists, Osteopaths,

and Chiropractors. Physical Therapists provide strengthening and work-hardening regimens, while Osteopaths and Chiropractors offer cost-effective medical interventions to help control, and even reduce, medical costs.

The Americans with Disabilities Act (ADA/ADAA) also plays an important role that can be factored into the comprehensive arsenal of strategies to deal with back problems. The ADA/ADAAA requires employers to provide "reasonable accommodations" for injured workers, and there is no more important application of this concept than for employees with back problems. Although some employers think that accommodating a worker appears to be sending the wrong message to the workforce at large, and something many employers may be unwilling to make, the outcomes of making accommodations are almost entirely positive.

Most accommodations cost very little, and making an accommodation generally will lead to the retention of a valued employee. Accommodating an employee with a back problem is a serious tool employers can use to find relief from the debilitating costs of back problems. Also, it is important to recognize that making a job accommodation is not the same as providing the employee with a "light-duty" assignment; these two approaches are diametrically opposed.

There is also a psychosocial factor in the mix. That is, psychosocial dynamics are more reliable predictors of impending back-problem claims than medical factors. CEC Associates, Inc., has long assisted employers to understand the psychosocial aspects of workplace disability through describing "learned helplessness" and "disability prone" concepts. Again, experienced, skilled Vocational Counselors and Disability Management Specialists can assist employers to recognize these social realities and develop strategies to control and reverse them.

Employers also need to recognize an increased responsibility to deal with this problem without important assistance from the federal government. One of the first actions taken by the Bush White House staff was to reverse a Clinton administration regulation on mandatory ergonomics under the Occupational Safety and Health Administration (OSHA). The effect of this reversal is that employers will not receive relief in respect to ergonomics in the workplace. As OSHA now stands, there will be no federal requirement and no federal moneys to implement ergonomic reforms in the workplace. That is not to say that employers need not, or should not, effect ergonomic adaptations; it is just that they will not be required to do so or assisted in doing so with federal funds.

Another angle of attack on the problem is through proactive claims management. This is especially true where the responsibility for treatments and compensation are either private insurance carriers or self-insured companies. Progressive claims management can assist employers to plan and engage "best-practices" disability management, and employers should avail themselves of these resources for program planning and implementation.

In summary, back problems are the single most significant cost factor in worker disability. The good news is that employers can take steps to deal with this reality. When they do so, they are rewarded with reduced costs and increased employee loyalty and dedication.

Part 2: Back Problems – Specific Issues

Workplace Accommodations for Back Impairments

The federal government funds an enterprise that focuses exclusively on assisting employers to find suitable and cost-effective job accommodations for individuals with physical impairments. The name of this entity is the Job Accommodation Network (JAN) located at the University of West Virginia. JAN is a branch of the President's Committee on Employment of People with Disabilities. Below are some back impairment accommodations developed by JAN.

- A maintenance worker with a back impairment was having difficulty moving reams of paper from one office to another. He was accommodated with a pneumatic lift table.
- A data entry clerk was having difficulty sitting for long periods due to his back impairment. He was accommodated with a sit/stand workstation, an ergonomic chair, and a copy holder.

- A factory worker with a back impairment inspected product on an assembly line 10 hours a day. She was accommodated with a sit-lean stool and anti-fatigue matting.
- A warehouse worker whose job involved maintaining and delivering supplies was having difficulty moving product from one area to another. The individual was accommodated with a vacuum lift, pallet server, and fork truck.
- A construction worker had to undergo treatment for a back injury during working hours. The individual was transferred to light duty and provided a flexible schedule in order to attend treatment and to continue to work full-time.
- A secretary with a back impairment needed to reduce the reaching in his job functions. He was accommodated with an adjustable workstation, a telephone headset, a copy holder, and an electronic filing system.
- A materials handler was having difficulty moving boxes from a shelf to a trailer for shipment. She was accommodated with a vacuum lift, a conveyor system, and a dolly.
- A professor with a back impairment needed modifications to make her work area more accessible. She was accommodated with a file carousel, an adjustable stool, an automatic stapler, an adjustable workstation, and an ergonomic chair.
- A mechanic with a back impairment was accommodated with anti-fatigue matting, a sit-lean stool, a jib crane, ergonomic/pneumatic tools, handle adapters, tool balancers, and work positioners.

JAN also provides the names, addresses, and telephone numbers of companies that produce specific ergonomic tools such as tool balancers, vibration reducers, pneumatic tools, and vacuum lifts.

To determine an appropriate job accommodation, JAN suggests a set of questions to consider:

- What symptoms or limitations is the individual with a back impairment experiencing?
- How do these symptoms or limitations affect the person and the person's job performance?
- What part of the back is affected by the impairment?
- What was the cause of the back impairment?
- What types of restrictions are there as a result of the impairment?
- What specific job tasks are problematic as a result of these symptoms and limitations?
- What accommodations are available to reduce or eliminate these problems? Are all possible resources being used to determine possible accommodations?
- Has the employee with the back impairment been consulted regarding possible accommodations?
- Once accommodations are in place, would it be useful to meet with the person with a back impairment to evaluate the effectiveness of the accommodations and to determine whether additional accommodations are needed?
- Do supervisory personnel and employees need training regarding back impairments, other disability areas, or the ADA/ADAAA?

Back Problems and Case Law

Since back problems are a persistent cause of lost work time, there is a comparable amount of litigation associated with the difficulty. The following are summaries of a few cases that grew out of back problem issues.
An airline employee with a 40-pound lifting restriction, who wanted to work shifts that did not require lifting, was ruled not qualified to perform the essential functions of the job, thereby denying the employee the right to change shifts. (*Summerville v. Trans World Airlines, Inc.,* 10 AD Cases 1522, 8th Circuit, 2000)

The Nevada Supreme Court affirmed a $2.5 million verdict to a plaintiff who was discharged after injuring her back and filing a workers' compensation claim. The employer's request that she return to work before being medically released and then "punishing her" with a demotion and major salary reduction was "a direct violation of public policy." (*Dillard Department Stores v. Beckwith,* Nev., No. 31378, 12/13/99)

A $250,000 jury verdict for an unskilled laborer with degenerative disc disease was reversed by the U.S. Court of Appeals for the District of Columbus Circuit. The court held that the employee was not disabled under the ADA because he failed to provide enough evidence that he was substantially limited in working. In a vigorous dissent,

one Judge said that the majority had set a higher standard of proof than was warranted under the statute, under EEOC guidelines, or under case law. [The plaintiff will appeal, and the case will be followed for a final verdict on the standard of proof.] (*Duncan v. Washington Metro Area Transit Authority,* D.C. Circuit No. 99-7073, 1/28/99)

A Michigan jury awarded a former Toyota worker more than $7.1 million under a state disability discrimination law because a supervisor forced the worker to perform tasks that resulted in a permanent back injury. (*Olsen v. Toyota Technical Center USA, Inc.,* Michigan Circuit Court, No. 96-9645266, 2/9/00)

In a back problem case, the U.S. Court of Appeals held that an employee cannot show that his employer failed to provide a reasonable accommodation in denying his request for reassignment unless he proves that a vacancy existed. The court said that the employee is first required to show that such an accommodation is possible. (*Jackan v. New York State Department of Labor,* 2nd Circuit, No. 98-9589, 3/3/00)

A hospital did not violate the ADA when it fired a nurse with multiple sclerosis and a lifting restriction, since lifting was an essential function of the nurse's job. (*Lenker v. Methodist Hospital,* 7th Circuit, No. 98-4183, 4/26/00)

Northwest Airlines was required to pay $200,000 to a former employee with a back injury because it did not grant her reasonable accommodations and fired her after she testified in a sexual harassment case. (*Mazeikus v. Northwest Airlines, Inc.,* Massachusetts Commission Against Discrimination, No. 95-BEM 3142, 4/26/00)

An employee who suffered a herniated disc as a result of unloading trucks was granted the right to proceed with an ADA claim. (*Hettler v. Zany Brainy, Inc.,* E.D. PA, Ca No. 99-3879, 9/27/00)

In a case that also involved a radiology technologist with a back problem, the court ruled that it found no requirement for lifting or pushing in her job description. The job description for this position required only that a radiology technologist be able to assist in transporting patients. (*Chen v. Galen Hospital ILL.* 17 NDLR No. 142, N.D. Ill. 2000)

The company did not provide documentation that a former secretary who had back injuries was not performing adequately. Nor did it show that she could not perform the essential functions of the job. The worker was qualified under the ADA, and the company should have accommodated her. It could not use poor job performance as a pretext. (*Wheaton v. Ogden Newspapers, Inc.,* 16 NDLR No. 207, N.D. Iowa 1999, No. C98-3029MWB)

In a Pennsylvania case, the court held that it was not clear from the evidence presented that the documented/required "essential function" to lift 50 pounds was indeed an essential function for the position. It ruled on behalf of the employee. (*Hunter v. Commonwealth of PA, Department of Corrections,* 15 NDLR 70 E.D. Pa 1999, No. 98-0358)

Back Pain and Conventional Treatments

Doctors and researchers at Rush Presbyterian-St. Luke's Medical Center in Chicago found that traditional treatment works about as well as spinal manipulation in relieving back pain in patients who have been in pain for three weeks to six months. After three months of treatment, both groups of patients experienced a 50 percent decrease in pain. The study was published in the November 1990 issue of *The New England Journal of Medicine*.

More Back Troubles

According to the National Center for Policy Analysis, back problems have become the largest single impairment alleged by people who file ADA/ADAAA suits.

More than 20,000 complaints citing back problems have been filed in the last decade and these complaints outnumber all other complaints filed that cite blindness, hearing impairments, paralysis, and heart trouble together.

Stretching Minimizes Back Injuries

Flight attendants with United Airlines have been taught to stretch to avoid back injuries. The exercises they mastered through the "Backsafe" program, of Future Industrial Technologies (800-775-2225), can be applied to office and manufacturing employees to help prevent injuries.

The before- and after-work exercises include:

- Neck stretches: Bend your head downward and gently upward. Slowly and fully turn the head to one side, then the other. Side bend the neck toward the shoulder, hold, and then look down.
- Back extensions: After sitting or bending, and especially prior to lifting or bending, place your hands on the lower back and gently push forward. Raise the chest upward and arch your back.
- Knee pulls: With the back supported, sit upright. Hold one knee and slowly pull it toward your chest. Hold for three to five breaths and then switch knees.
- Shoulder rolls: Roll shoulders forward in three large circles and then repeat the action backwards.

Part 3: "Well-Managed" Companies and Return-to-Work Programs

by Fred Heffner, Ed.D.

The "Well-Managed" Concept

We have learned from Tom Peters and others that we can look at American companies in terms of how well they are managed. Peters has written a book (and has lectured widely) on the best-run companies in the country. Therefore, we have, in this country, a concept of superiority of management skills and how that superiority (or "excellence," to use Peters' term) translates to viability and profitability for those companies that practice it. Managing a company successfully has at least two fundamental premises as constants. They include:

- Cost containment is a critical factor in the process.
- People (i.e. workers) really and truly matter to the employer.

So, Peters insists that a company that fails to keep a close eye on both of these critical factors is likely, in the long run, not to succeed.

The central point in this article is that the well-managed concept includes the idea that any company that does not have a structured Disability Management/Return-to-Work Program cannot consider itself well managed. A work organization without a Disability Management Program (DMP) cannot be considered as having a deep and abiding concern for cost containment, and a company without enough interest in its own employees to have a proactive DMP certainly cannot be thought of as truly caring for its people.

The "Well-Managed" Question

The fundamental question is, in light of this "well-managed" concept, why are there still employers who do not actively promote the employment and re-employment of individuals with disabilities? Other questions that bear significantly on this issue include:

- Must a company be "large" before it can benefit from hiring individuals with disabilities?
- What are the specific benefits that accrue to all employers if they hire individuals with disabilities?
- If a company does not employ individuals with disabilities, precisely whose responsibility is it to work with that company to enlighten it on its responsibility?
- Is the idea that finding qualified employees will become harder and harder as we move into the 21st century valid (as predicted in the U.S. Department of Labor's *Workforce 2000* study)?
- What roles can companies that already employ individuals with disabilities play in helping non-participant companies?
- What are the real concerns of management in terms of employing individuals with disabilities?
- If a company is applying for ISO 2000 certification, can it afford to muddy the process by hiring individuals with disabilities?

- How are employers to know that employing individuals with disabilities is good for the bottom line?
- Do individuals with disabilities need to be more qualified for a job than the general population?
- Does the existence of the ADA/ADAAA represent an intrusion into business by the federal government?
- Is the accommodation requirement of the ADA/ADAAA an unwarranted encroachment on the private sector?
- Are medical costs the only concern for employers, or are lost-wage costs also important?
- Why do most employers have trouble appreciating the positive outcomes available through a return-to-work program?

So, we are left with the questions of how we help employers understand and embrace the ADA/ADAAA rather than fear it and who is responsible for educating every employer in America on the concept that each job should be defined in terms of its essential functions as a minimum requirement for maximizing profit. Who will champion return-to-work as the goal for every DMP?

Return-to-Work Programs

The logical outcome of being well managed is having a structured Return-to-Work program in place and working to the advantage of both the employees and the employer. Significant aspects in Disability Management include the following particulars:

- Employees want to work and employers are better served by returning injured employees to work.
- The concept of "Light Duty" is obsolete and needs to be replaced by a Transition-to-Work program.
- A DMP starts with a job analysis of every job in the company and written job descriptions based on the "essential functions" of each position.
- Human Resources personnel need to learn (and apply) new skills, including job modification, job accommodation, and ergonomic design.
- Companies need to develop and implement wellness and safety programs regardless of how few employees there are.
- If the bargaining unit in a company resists return-to-work programming, they are resisting on the basis of some hidden agenda, not the return to work.

Some companies (General Motors, for example) have begun to have employees reapply for their jobs. That is, everyone throughout the company in a specific job classification is out of work but can apply, along with others (including outsiders), for their positions. The idea is that some jobs have changed so drastically that many incumbents no longer have the skills needed to perform the job effectively.

Additionally, this is certainly true of many professionals responsible for helping top management make informed decisions about their Workers' Compensation and Disability Management Programs. Human Resources and Risk Management professionals who do not understand such concepts as transition-to-work, essential functions as determined by job analysis (not observation), job accommodation and assistive devices, ergonomic design, case management, auditing and re-pricing medical bills, and utilization reviews, simply do not have the skills needed to be of value to the employer. The expertise of Certified Rehabilitation Counselors, for example, can be of significant value to employers seeking consultation services. Per the CRCC *Code of Professional Ethics* (Code C.1.e.), rehabilitation counselors "are knowledgeable about local, regional, and national systems and laws, and how they affect access to employment,education, transportation, housing, financial benefits, and medical services for people with disabilities. They obtain sufficient training in these systems in order to advocate effectively for clients and/or to facilitate self-advocacy of clients in these areas."

Transition-to-Work Planning

Historically, many employers have used what has come to be known as "light-duty" employment for employees returning to work. The problems with light-duty employment are that it:

- does not prepare the employee to return to work through progressive work hardening,
- sets no criteria to tell when the employee is ready to move from light duty to full duty,

- has no relationship to the kind of work to which the employee is expected to return,
- could be determined to not be in compliance with the “qualified” worker aspect of the ADA/ADAAA,
- is demeaning to the employee, and perhaps most importantly,
- does not serve the employer’s interest to return the employee to full productivity at the earliest possible moment.

What well-managed companies use in place of light duty is a carefully thought out “Transition-to-Work” (TTW) plan. In a TTW plan, the return to work is arranged in incremental steps designed to work with a Functional Capacity Evaluation and a carefully developed schedule that projects both milestone dates and the culmination date. The plan is designed to return the employee to full productivity by a specific date, and everything required to do that is spelled out specifically and documented.

In addition, all of the participants in the process (the injured worker. the doctor, the supervisor, the human resource professional, the bargaining unit representatives, and others) assist in the structuring of the plan and play an active role in its fulfillment.

There are materials available to assist employers to plan and implement Transition-to-Work plans. These materials are the basic components from which a customized plan can be constructed. Generally, such plans are available to employers under a variety of consulting agreements, and specific contracts can be drawn to tailor the basic materials to the unique needs of individual companies.

Transition-to-Work planning is not something that well-managed companies have because it is a good thing to have. TTW planning is an enormously effective cost-containment process and is designed to save all companies, regardless of size, significant money.

Strategies for the Use of Independent Medical Examinations

On Friday, April 5, 2002, CEC Associates, Inc., of Valley Forge, Pennsylvania, sponsored a workshop on the use of the Independent Medical Examination (IME) in contested claims. The presenters at the workshop included the following:

- Jasen Walker, Ed.D., C.R.C., C.C.M.
  President, CEC Associates, Inc.
- Jane Lombard, Esquire
  Swartz, Campbell & Detweiler
- Thomas Grier, Esquire
  Law Office of Thomas Grier
- Timothy J. Michals, M.D.
  Forensic Psychiatrist
- Wilhelmina Korevaar, M.D.
  Forensic Physician specializing in pain

The following materials are the transcription of the presentations.

The Importance of Being Right the First Time:

Jasen Walker, Ed.D., C.R.C., C.C.M.

Why did we conceive of this workshop, how did it begin, and why did we choose IMEs? In personal injury lawsuits, medical malpractice cases, slips and falls, automobile accidents, liability matters, and workers' compensation cases, IMEs serve a purpose. Most of us think that the purpose is to, in fact, describe medically what it is that an individual is all about at a particular time. But that is really not what the independent medical examiner is asked to do for the lawyer.

The lawyer needs to use the IME and the testimony of the independent medical examiner as a platform to defend or to plea the notion of disability, because disability then means damages in workers' compensation terms, and whether or not you have an earning capacity. In liability matters, the damages are usually employability and earning capacity. There is always an issue of causality, but we realized very quickly in our development as an organization that IMEs, for very different reasons, fell short of the ultimate goal. That goal is to assist an adjudicator in understanding what disability is. We have found that most don't understand the concept of disability. Most of us still conceive of disability as a medical concept, and it is not. Disability may result from medical impairment. Disability is an occupational concept. It's a social concept. We too often rely, sometimes unfairly, on the medical examiner to give us information about disability. We realize that if we could offer good IME services, we could teach the world, as grandiose as it sounds, about disability. We've been partially successful at that. You have some of our literature. On the literature is a logo. This logo is not like a GE logo. Everybody knows what GE stands for. Everybody knows that GE stands for General Electric, and everybody knows what General Electric does. They make airplane engines and light bulbs and money. Our logo has, for us, an equal significance in terms of its power to send a message. Just understand that this logo is four hands coming together. Dr. Korevaar can tell you that anatomically, no one has four hands. There is four-handed dentistry, but that's a job description, not a person. The four hands are not about a person, and they are not about disability. The four hands mean that two hands might represent a person who has been injured or impaired, and the other two hands represent someone else. Therein lies the power of the logo.

Disability is not a function of one person falling down, being injured, becoming ill, and therefore, being irresponsible or being disabled or taking advantage of someone else. Disability is often a dance between two people. You can't be disabled unless someone is not allowing you to work. You can't be able to work unless a physician says to you that you are released to work. The point is that disability is the function of more than one person. Parenthetically, rehabilitation and return to work also requires more than one person, more than the patient or the injured worker. It is indeed two people, at least two people. Ladies and gentlemen, if there's anything you take away from the workshop today, please understand that disability is a social concept that is often induced. Disability in this culture would not exist unless someone was indeed dancing, or malingering with the person who claims to be disabled.

Therefore, I would like to introduce another idea to you, and it's not my idea. It comes from Ken Mitchell. Ken introduced to me the concept of co-malingering. We sometimes think of someone who is claiming disability as someone who is malingering. But I ask you, who is malingering, the injured person who says they can't work or the physician who says the injured person can't work? Who's malingering, the injured person who says that they can't work or the spouse who says, "Honey, stay home, don't work"? Who's malingering, the injured person who says they can't work or the employer who says, "You can't come back and work here unless you're 100 percent"? How many of you every day work next to somebody who's 100 percent?

Disability can be induced. Disability is induced in the insurance industry with something called subrogation. That means that if somebody is injured and there is a third-party claim, all rehabilitation must stop so that more money is not spent and whatever has been already paid can be recouped. Disability is induced. I don't know how many people I've seen that come in and say to me, "Dr. Walker, I can't work. I know I'm here for a disability evaluation, but I can't work." I say, "Tell me why you can't work." And their immediate response is, "Well, I receive Social Security Disability Insurance." I look at this person, and I test them. Anatomically they look like a normal person to me. And I get a report from the treating physician saying they can do this or that physically and there are surveillance films showing they are doing this or that, but they are still telling me they can't work because they receive SSDI.

So, we know from experience that this idea of disability is a complex thing, and we also know that the IME is a critical component in explaining to the court, jurors, and a judge (or a group of panelists) that a person has functionality, a person can sit, stand, walk, etc.; the person can do things. That becomes only part of the puzzle. I am not a medical examiner, but I have been in the courtroom many times over the last 20 years in different jurisdictions: workers' compensation, Social Security, liability matters. In front of adjudicators, panelists, federal court, civil court, and even family court regarding divorce and whether or not a spouse has disability. So I would like to be bold enough to suggest to you that this idea of being right the first time is critical for any forensic expert, including IMEs.

I am going to try to walk through some ideas with you about what it takes to be right the first time. The other day I was in federal court and people were asking about my expertise. After I was asked to testify on behalf of the defense, the plaintiff lawyer got up and said, "Well, Dr. Walker, so you're the hired gun." There was an objection, but he got it in. Ten years ago I couldn't have done this. I responded, "Well, if I am sir, I'm the straight shooter." Only because the point was I wasn't there as a hired gun, and I learned from Tim Michals that you're there to help, you're there to help straighten things out, to assist the court in understanding a particular matter.

Independent medical examiners must appreciate that when performing an IME, they are there to assist the court in understanding more about the plaintiff's medical condition. That's their job. Someone, a court official, one of the lawyers, has hired the IME physician as an assistant to explain their expertise and their understanding of this person's condition, functionality, prognosis, diagnosis (whatever it might be) so that people can make decisions. The IME physician doesn't have to really think about anything else regardless of what a lawyer might be trying to imply about their credibility. So that's a key point: regardless of what is heard, independent medical examiners are not hired guns. They are people who are asked to assist in the adjudication process because they have a particular expertise. That's good.

Now, what you are going to hear in a moment may not be completely the case from everybody's perspective, but those of you who do IMEs, that's what I want you to believe. Regardless of what you've been told, in order to assist, you have to have all of the information about a case. Those of you who are lawyers or claims people, if your independent medical examiner asks, don't make them crawl, for the information that they need in order to assist you. Don't embarrass them in court when they don't have the information. Those of you who are plaintiff attorneys, don't be cheap. Do not send half of a deposition because you think the person only needs to read so much of it. Even if the information is irrelevant, all the jury has to hear is, "Well, Dr. Michals, you didn't see this, this, and this." Even if it's irrelevant, even if Tim says, "I didn't need to see that," the jury will always suspect you didn't see it all. Know your expertise as an independent medical examiner. We have lost millions of dollars in workers' compensation, long-term disability, and liability insurance; everyone here is a consumer of those products.

Everyone here has to have insurance. We have lost trillions of dollars in this country because we have confused two terms: impairment and disability. Physicians are not trained to assess disability. That is not their expertise,

and I use as support of that The American Medical Association's *Guides for the Evaluation of Permanent Impairment*. That's the book that helps Dr. Jaeger and other people to establish an impairment rating.

In the preface of the Guide, there's a clear and distinct difference between impairment and disability. It's well written. It's more eloquent than the following example, but this you will remember. If I lose my middle finger and I am a concert pianist, I probably would have a disability. That's both my impairment and my disability. But if I lose my middle finger and I'm an over-the-road truck driver, no matter how much I try to convince my northeastern Pennsylvania family physician that I need that middle finger in order to direct the traffic of others and that that's an essential function of my job, that, I assure you, is not a disability. Or Joe the truck driver says, "Hey, look, I lift 150 pounds." The doctor says, " Well, it's pretty close to your pinky finger. Your last two fingers are your most powerful fingers, so maybe you do have a disability." But what Joe doesn't tell the doctor - those of you who establish IMEs and create IMEs, and then arrange for IMEs and make IMEs happen - the doctor doesn't have a job description. Therefore, the doctor is in the dark about what Joe actually does. The doctor thinks Joe lifts 150 pounds, but Joe only does that one time a year right around the Christmas rush, and he probably could get help doing it. But that's not what Joe wants the doctor to hear.

There is a difference between impairment and disability. I don't know how many IME reports I've read that have included, "So-and-so can't work." Then everybody is scurrying around saying, "My God, we have a terrible claim here. Dr. John said that so-and-so can't work," as if that were a statement by God Almighty. I say, now wait a minute, Dr. John is not a vocational expert, but he said he can't work. But I have gotten your attention, right? Remember the middle finger. So be careful driving home.

Don't assume the purpose of the assignment. Independent medical examiners should not assume that they've been asked to examine someone for a particular reason. Claims people and lawyers make sure that the physician does understand what you expect from him. It's almost knee jerk now that when an evaluation comes into my office, I know what it is that people are asking for. But the moment I in fact make that assumption, that is potentially a problem. So ask. If the examiner does not know what it is that the referral source is asking, they must ask. Pick up the phone and ask. The IME physician is allowed to talk to these people. They may be asked what was said during court, but they can ask.

Understand the IME examiner role in the bigger picture. IMEs are the basis for evaluating loss and damages. Medical examinations only take you a third of the way there. There is a type of analysis of what constitutes damages in a liability case. It starts with medical assessment, requires a vocational evaluation, and then ends with an economic assessment. People can be impaired and still work, but they may not be able to make as much money with their impairment as they might have if they had not been injured. So, the point is that medical examiners need to understand the context for which they offer opinions.

We all know the importance of addressing functional capacities. But we're still in the evolutionary stages of disability evaluation. I've seen this happen. The nurse will fill out the functional capacity assessment form and hand it to the doctor, or the physician will interview the person and say, "What do you think you can do?" We're in a state of changing the art with functional capacities evaluations, but the point is whether the expert is an orthopedic examiner or a psychiatrist or a specialist in pain, ultimately their testimony should speak to residual functional capacity, whether those be physical or mental capacities or both, not disability conclusions.

And that's the examiner's role in the bigger picture. They need to understand that before they even go into the assessment. They may want to see surveillance films. Some independent medical examiners, I assume, will say that they don't want to see surveillance, but on the other hand, what people do on film is as important, if not more important than, what they tell you they can do.

I tell people who work for me, when you do rehabilitation, don't play claims person, don't play lawyer, and don't play physician. You are a rehabilitation professional. I tell independent medical examiners to use standards and not just what they've been taught in medical school, but what God, their mother, and opposing counsel would expect of them.

I will point out that the *Code of Professional Ethics* for Rehabilitation Counselors addresses the issue of professional responsibility extensively. In that section, the *Code* includes information regarding "boundaries of competence." The *Code* (D.1.a.) states:

Rehabilitation counselors will practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Rehabilitation counselors will demonstrate a commitment to gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. Rehabilitation counselors will not misrepresent their role or competence to clients.

Similarly, the CDMSC also speaks to this issue in their *Code of Professional Conduct* (RPC 1.01):

Certificants shall practice only within the boundaries of their competence, based on their education, training, appropriate professional experience, and other professional credentials. They shall not misrepresent their role or competence. They shall not attribute the possession of the certification to a depth of knowledge, skills, and professional capabilities greater than those demonstrated by achievement of certification.

Similarly, case managers also have a *Code of Professional Conduct* standard (S2) that speaks to competency:

Case Management competence is the professional responsibility of the Board-Certified Case Manager, and is defined by educational preparation, ongoing professional development, and related work experience.

I frequently hear independent medical examiners being slandered. The other day I was in a meeting where a defense lawyer and a plaintiff lawyer were arguing. The plaintiff lawyer said that he don't care if it's so-and-so or so-and-so, you know they're both lying. He actually shared their names after slandering them. I want to remind you that being an independent medical examiner is an honor. I want to remind IME examiners that they are there to assist the court in helping make a decision, and one of the ways to really appreciate that is that a lot of times the expert will disagree with treating physicians, and they shouldn't feel guilty about that.

Treating physicians often make clinical mistakes because they are too close to the problem, too close to the forest to see the trees. Treating physicians are there to heal people. The treating physician's job is to align himself with a patient in a therapeutic process. You can't have a therapeutic process unless you have some rapport with the person. If you have rapport with the person, you're going to like the person. Some people not only treat the person, but treat the rest of the family as well. Treating physicians can be co-malingers even if they are not consciously aware of it. They can be too involved with the patient. Sometimes I'm asked the question, "Well, don't you understand that the treating physician knows this person better than the IME person, Dr. Walker?" I say that is not necessarily true. Maybe that treating physician is a little myopic. Maybe they are too close to the forest to see the trees.

The idea that the IME physician is looking at all of the information possible and they are an objective observer and don't have an agenda, regardless of who's paying them, is a very powerful method of assessment. So once they've done their examination, they need to do an evaluation report, and it has to be readable and have an introduction, a body, and a conclusion. Most people will read the end of an IME report first. There, the examiner ought to state their conclusions with medical certainty.

The IME physician's job doesn't end with the report. Hopefully, the lawyer will use the examiner as a consultant in the process of preparing for trial. An independent medical examiner doesn't have to be like that lawyer I heard bad-mouthing people, but they can be a really good consultant to the lawyer in critiquing the other side's expert. They can be a really good consultant in helping that lawyer prepare in asking the examiner the right questions, because if they don't have the right questions asked, they won't be able to tell the story. And ultimately, that is the IME physician's job – to tell the story, not a story, *the* story – and that's important.

The *Code of Professional Ethics* for Rehabilitation Counselors speaks to "consultant competency" in Section E.2.b., stating:

Rehabilitation counselors will be reasonably certain that they have, or the organization represented has, the necessary competencies and resources for giving the kind of consulting services needed and that appropriate referral resources are available.

This is important too. An IME physician can manipulate language in reports to confuse the hell out of people, or they can use their language so clearly that it says scientific things in lay terms. Examiners will ultimately achieve a better perception, not only from the reader of their reports but from the people who are listening to the story later on in court. And finally, this is my favorite to teach everybody on my staff. They are so sick of hearing me say this. PEF – preparation, execution, and follow-up – there is nothing you do successfully in life unless it takes three steps. There are three parts: a beginning, middle, and an end. There is a preparation, an execution, and a follow-up.

As independent medical examiners, and those of you who are working with them, it's the responsibility of the independent medical examiner to pick up the phone and ask how did they do. They don't have to say that in an insecure way. If somebody perceives the expert as insecure for asking, they give them a whole bunch of stuff like, "You did really well, doctor." The examiner is asking for feedback. Unless they do a lot of videotape presentations and they review them all, it's hard to look at themselves as an expert witness live in court. A lot of times the lawyers will poll the jury. They will survey the jury after a decision is made. They will say, "What did you think of this witness, and what did you think of that witness?" There is a lot of good information out there for the IME physician, and as an independent medical examiner and as a lawyer working with him and as a claims person, we should encourage that process, get feedback, and learn more about individual styles of a witness. The IME consultant should feel free to follow up about his/her presentation while remaining disinterested in the outcome.

Coordinating and Scheduling the IME from an Attorney's Perspective

Jane Lombard, Esquire

Thank you and good morning. I was called by Jasen yesterday to fill in for Jim Haggerty this morning, and when he told me the topic was IME physicians and coordinating and scheduling the IME, it gave me a great opportunity to reflect on what I actually do and how frequently I do become involved in the IME process and the deposition process. I practice workers' compensation, and the IME is integral to the workers' compensation process. It will make or break your case. If you don't receive an accurate IME, you're often left in the situation where it's six months before you can have a reevaluation. It is critically important to get it right the first time and maximize the opportunity.

What I would like to do this morning is talk about some of the things I look for in an IME physician; what I look for when I am putting together the referral for the IME physician, when I am preparing the IME physician to testify, and most importantly, when the IME physician is testifying; and some pointers that I look for from the defense perspective that will help in testimony. The best IME report in the world is not helpful if it can't be backed up with persuasive testimony.

Choosing the IME physician: What do I look for? At a minimum, I'm looking for qualifications, and that's generally a board certification in the field of expertise. Sometimes I'll have a physician who is board eligible but simply hasn't put in enough time to take the boards. It's not fatal to the situation, but it's not ideal. I want someone who has that baseline level of the board certification.

You want to match your expert's qualifications with the type of case you're dealing with. If you have a back strain case, you don't necessarily need the top neurosurgeon. You want a board certified orthopedic surgeon who is capable of assessing a back strain or you might need a physiatrist depending on the length and the nature of the impairment. I was going to say disability, but I was paying attention.

You want to look for that match between the kind of case you have and what this doctor's practice is all about. One of the types of cases that I frequently deal with is upper extremity injuries – carpal tunnel, the epicondylitis – things like that. Oftentimes, the choice will be between a general orthopedic surgeon, who certainly has the expertise to deal with the upper extremity case, or a hand surgeon, who not only has the orthopedic experience, but has that extra measure. I think that in these types of cases, particularly where there has been a surgical intervention, I'll look for that extra measure of qualifications. I think that that's where I can often score some points because the

plaintiff's expert doesn't always have that extra measure of qualifications and that's where I can differentiate my expert. That's what I will hope to do.

One of the questions that I'm often faced with is, do I want the top guy in the field, the expert? That's a difficult question. Sometimes you do. Sometimes the nature of the case is going to demand the top guy, the one who has published the most, the one who in the country is regarded as the "go to" guy. But there's a downside to that. One of the things I also look for in my IME physician is accessibility and flexibility, and you don't always get that if you want the top guy. He's not going to be available to take your phone call. He might not have hours to look through your medical records, and when it comes time to schedule his deposition, he might not be the most available person. So there is a downside, and that should be considered when you're choosing this physician.

Finally, I want to talk about the hired gun, the overused expert. They are out there, and we have to deal with it. But they are out there on both sides, and you are going to see the same family physicians and the same treating physicians on the claimant or plaintiff side. At a deposition that I recently attended, a physician gave this explanation for why he believed that he was an independent medical examiner. He said that he is independent because he makes one assessment. He sees this person for one examination and makes his conclusions. It's all based on that and then he walks away. If he's going to make treatment recommendations or he's going to say this person is in need of surgery – he's not going to do that – he's going to turn it over to someone else. He doesn't have a vested interest in maintaining the person in a system. From that, they are able to say that they have some independence. I think it's a good way to handle it.

Where you are using an expert who frequently testifies and is very involved in the litigation system, it's important to handle that with grace and candor. It will come up, and it needs to be dealt with. It doesn't serve anyone's purpose to be cagey or to hedge the question. Deal with it forthrightly, and I think this gets it out of the way and it's done with.

The IME introductory letter is very important. This sets the tone. This gives your expert an idea of what you want, how you want it, and what information you have to give to him. So here are some pointers on preparing the letter and forwarding the letter.

Before I get to that, let me just explain a little bit about how I often get the case, and I don't often have the opportunity to structure the letter from the start or choose the experts. A lot of times, that is already done for me, and when I get the case, the IME report is in there and then I'm playing catch-up and that's tricky. You have to be careful in seeking clarification based on what they've already decided. Ideally, I would like to select the expert, and I would like to make contact with the expert prior to the examination. I would like to give him an introduction to the case, but the reality of the situation is that doesn't often happen, and one of the situations I find common is when the IME is done and all of the information was not available. So I'm playing catch-up, and I'm forwarding information in dribs and drabs.

This is particularly true in workers' compensation settings because we haven't had a long period of discovering to gather all of this information, which is dynamic. It's happening as we're litigating. So it's a constant string of information that you're trying to feed the expert. What you want to do when you craft that letter is set forth the procedural status of the case, where is it, what's happening. Set forth the facts and identify and summarize the medical records, provide the expert all of the records that you have and continue your efforts to get the records if you don't have them all. Send them the films; don't just send them the reports. That is very important. If they just have a report of an MRI, then they're stuck with the conclusions of the radiologist. If they actually have the MRI film, they can make their own interpretations.

Recently, in the United States District Court, in connection with a motion for summary judgment, Judge Koffman rendered a memorandum addressing the sufficiency of an IME letter. What he did was deny the motion for summary judgment. What the judge found was that the IME letter was somewhat inflammatory, and he thought that maybe that could form the basis for a bad fake action. I think that this really kind of hits home with how crucial it is that the IME letter not be overly suggestive, not be inflammatory, and be as neutral as possible while getting your point across. Don't use words like "this was a minimal incident and the plaintiff is still out of work this much later." Let the doctor make those conclusions, and you set forth the facts. Let him interpret the data. Stay away

from any kind of suggestive language. Importantly, ask the questions that need to be answered. Set them forth, put them in bullet format, and let the IME physician know what you're looking for.

In a workers' compensation setting, the doctor is often forced to assume certain facts that he might not accept on his own. This situation arises where a judge has already determined what the scope of the injury is and maybe another doctor has disagreed with that, but the fact remains they're stuck with it. For subsequent IMEs, the attorney has to deal with what the judge has determined the injury to be. Make sure the doctor knows that. I think it's also important to offer the expert the opportunity to contact you for further clarification or for further information. It avoids having to seek that addendum report. You make sure that you and your expert are on the same page. I think that's a synopsis of what I'm looking to do with that letter.

The report itself – Jasen touched on this – we want to be comprehensive, and we want it to identify the history. We want it to have physical exam findings. If there are records that have been reviewed, identify the records that are important. We don't need a narrative of every single office visit, so that the IME report is 30 pages long, and it's just too long. Hit the highlights; we can flesh it out later. But the diagnostic studies are obviously important. Where they need to be distinguished from physical exam findings, do that.

Most importantly, in the report, answer the questions that have been asked and answer them with specificity. I'm looking for an assessment based on recovery, so tell me if he's recovered. Don't hedge it – tell me yes or no. Let me know if I can go forward with this report, or if I have to wait six months. One of the things that I don't like to see in an IME report is recommendations for further tests, for further treatment, for where the examiner would take this if they were treating the patient; they're not treating the patient. I'm asking the examiner for an opinion based on the information that I have available to me and the information that they have based on their examination and review of the records. Sometimes it's not possible, but be definitive and give me an answer based on that information.

Once we have an IME report that we can utilize and we're going to go to trial or to continue to try a workers' compensation case, the deposition is set up and we prepare the witness. A lot of times, this is the first contact I have with the medical expert. I wasn't involved in the report preparation, I wasn't contacted by the witness when he received additional information, so it's that half hour, 45 minutes prior to his testimony that gives me the opportunity to meet with the doctor, make sure that we're on the same page, and make sure that we all know what the purpose is here.

It, unfortunately, happens way too often that you meet with the doctor, and the doctor will for the first time say, "What was this case about?" or "What's in my file?" or "Now, tell me where are we supposed to be going with this?" My clients are paying a lot of money for this. There's nothing worse than the doctor using that prep time before the deposition to familiarize himself with the file. At a minimum, the IME physician should know what's in their file and know their report before I step into their office. Sometimes there will be new information, and that preparation session gives the opportunity to address the new information.

Some witnesses are very reluctant to be prepared. They want to talk about the weather and current events. They know the case, and it's a challenge but they need to maintain focus. An attorney needs to make sure that the examiner knows what is going to be asked and what points need to be clarified in their report. Most importantly, I try to use that preparation time to alert the expert as to where I think cross examination is going to focus and to give them a heads-up if it's going to be a particularly challenging counsel on the other side, or if it's going to be particularly lengthy.

Finally, the testimony. I've broken this down to the top five rules to giving persuasive testimony, and that's the ultimate objective here. Again, the best report in the world isn't going to help you if you can't back it up or you can't persuade a judge or a jury.

Explain findings with lay terms and give examples. One of the things that we often see is IME physicians indicating non-anatomic findings. Well, a lot of people don't know what that means. I had one doctor explain it pretty well. If somebody injures their right knee and they come in with right-knee complaints, and the IME physician examines their right knee and they are complaining about it, that's appropriate. That's anatomic. However, because it's part of a comprehensive examination, the physician is also going to examine their left knee, and if while examining their

left knee, they complain about their right knee, that's non-anatomic, which doesn't make sense medically. I think that explanation kind of puts it in perspective for most lay people.

Be concise and hit the high points again. As in their report, the IME physician should hit the high points and elaborate where necessary. I think defense counsel will probe and will seek further explanation and further clarification where needed. But from experience, judges and juries have limited attention spans. I know in the workers' compensation setting, we do trial depositions. Then we hand the transcripts to the judge, and the judges groan if they see a transcript that's three inches thick. As an attorney, you just know that they aren't going to read it; they are going to page through it. So hit the high points.

Remember it's an opinion that the expert is ultimately there to give. It's the opinion that is going to wrap everything up. The IME physician's opinion is within a reasonable degree of medical certainty and in workers' compensation, that has somewhat of a different meaning than in liability cases. We're not tied to the same rules, and we're basically asking, "Can you support what you're saying?" It's not as strict a standard. One of the frustrating things in taking testimony is where you have an expert who runs through the history and runs through the exam and explains things and everything is just very elaborate, and then you say, "Doctor, do you have an opinion within a reasonable degree of certainty and what is that opinion?" And it's yes or no, and then it ends there. And a lot of times, especially when it's a written transcript, the judge will fast forward to that opinion question, and that's where I want the examiner to elaborate and that's where I want them to tie it all together and that's where the one-word answer doesn't necessarily do it.

During cross-examination, listen to the question, answer the question that is asked, and then use it as an opportunity to advocate. I think a lot of IME doctors and a lot of experts look at their job as finished: they got through direct, they gave their opinion, and now they just want to get through this cross to get this over and done with. I think the best testifiers are those who use cross examination as the opportunity to reinforce their opinions, take the questions and turn them on the plaintiff or the claimant's counsel, and use this as another opportunity to drive home your point.

The most important rule – and I cannot stress this enough – is stay cool, stay calm, stay collected, and do not argue. I had a deposition recently where direct went beautifully. The doctor explained his opinions, everything was concise and consistent, but five minutes into cross examination, he completely lost his cool, was fighting with the plaintiff's attorney, and it just does more damage than you could possibly imagine. So if IME physicians are going to put themselves into this setting, they should not allow themselves to be goaded. That's what cross exam is going to try to do, so maintain your cool.

An Attorney's Perspective on IMEs

Thomas Grier, Esquire

I put together a list of things that I found helpful over the years in working with IMEs, and I'll try to suggest some things that are helpful or that I have found to be helpful in the past. First, for a plaintiff and a defendant, one needs to select a physician who will ultimately testify, and I think it's probably helpful to think of where this case is ultimately going to go, which is in front of a judge or a jury. It may not get there, but you want to be ready for it if it does happen.

From our perspective, our first choice is usually a treating physician. A treating physician may not be the appropriate person to have testify, and you may want to select a specialist. There are a couple of ways to go about it. One, there is a service that will find a physician for you. My experience has been that I've been better off with referrals from friends or acquaintances. There are lawyers on both sides, the plaintiffs and defendants, who I am friendly with who will share with me who they think are good doctors. But there are also doctors who will tell you that Dr. so-and-so is good for this or she's good for that. That I find to be the most helpful because the doctor or the expert can be an awful lot of help, and if you look at his or her purpose as being more than just sitting in a chair and testifying, but educating, helping, and making suggestions along the way, you can get a lot out of an expert other than just testimony or an opinion.

I think it's important that you find somebody you are comfortable with and that you set the ground rules at the beginning. Find out whether the doctor is flexible in terms of time and find out whether he or she is going to get

upset if trial dates get moved, if he or she is going to be available in the morning or the afternoon, etc. Those are things that you can generally get set at the beginning, and if you know you are going to have a problem with somebody's schedule and you know that this person is only going to testify by videotape, you may or may not want to keep that person as your expert.

Jumping ahead to that, there are three ways for us as trial attorneys to present an expert's testimony: we can do it live, and most of the time we want to do it that way, but there are some times that we can't; we can take a videotaped deposition; and sometimes we can just have the transcript read.

There are times, when you might think at the beginning that you want to have Dr. X come in and testify," but he's a hideous person. We had a case a couple of years ago with a family physician who was a really good doctor, well spoken, very intelligent, and made a great witness, but he weighed about 350 pounds, so we took his videotape deposition, and we had a dark backdrop so he looked almost normal. Several years ago we had a cardiologist from the old PCOM, and the defense attorney and I were good friends. We rode out to the deposition together, and he was asking me on the way up, "Why are you taking his deposition? Why don't you bring him in and videotape?" So we got to the doctor's office, and we took his testimony. We were driving home, and he told me that he knew now why I was doing it that way, because the guy looked like John Candy, and you can have some attractive, well-spoken person read that testimony at a trial.

Now, obviously the best thing is to have somebody come in and testify live, but you want to make sure that that person, when he or she does come in, is going to want to be there and want to help and is not going to be a giant pain in the ass to have to come over to the courthouse for an hour. Because it shows. People can tell whether a witness is sincere or not. Try to get to know your expert, be friendly. These people can be very helpful and guide you as you work through a case. Don't be shy about asking questions of your experts. Don't be shy about asking for his or her time. I found that a lot of these folks, even though they may not be at teaching institutions, like to teach. They like to instruct.

I like to teach and see the light bulb go on, and I think a lot of folks are like that. Some of you may know Dr. Fillinger, a pathologist; he helped me with a case a few years ago, and I went to see him several times. He loved just walking through what happened to my client. When he had a question, he'd pick up the phone and call another physician and ask if they thought this was possible or this or that. He helped me to understand exactly what had happened so that I could speak intelligently about it, and that's important too, that you understand the mechanism of the injury or the mechanism of the condition, so you can speak intelligently about it and you can ask the right questions or sort of go in the right direction. It might even lead you from one expert to another because the specialty is more appropriate for when there is an ultimate testimony.

You need to be careful about your correspondence. There are a couple of things. One, is don't be familiar. You may have known someone for 20 years and perhaps even seen the expert socially, or you're neighbors. But keep in mind that anything you put in writing is probably ultimately going to be seen by the other side and the judge or the jury as well. So don't be familiar. My letters to Dr. Walker are Dear Dr. Walker, not Dear Jasen. Somebody might ask a question or that might prompt somebody to ask the question, "How well do you know the plaintiff's attorney?"

Questions come up about how biased this expert may be if the expert and the attorney socialize. It's a professional relationship between the expert and the attorney, so it should appear to be that way. That is the sort of thing that ultimately somebody is going to hear or see, and I've always thought IME is a misnomer. But people talk about IMEs as somehow mythically making the person who's performing the evaluation independent. I recently received a note from a defense attorney telling me that he's enclosing a questionnaire forwarded by "Dr. X, our neurologist," who will be conducting an IME on your client on February 7, 2002. Now, *our* and *independent* don't belong in the same sentence. Sometime, somebody is going to see this, and when the doctor testifies, he is not an independent physician. He's their doctor, so how good is his opinion?

Don't ask an expert to do too much, but some experts know what they're doing and get out of the way. There was an orthopedist who practiced in Philadelphia a few years ago. He knew exactly what he was doing. The thing with him is that he knew to get out of the way. Let them do what they do, and let them do it well.

There are other experts who think they know what your job is, and they tell you. You have to sense that in the same way that you know you've got somebody who knows what he's doing or what she's doing, you may also have someone who doesn't really know what he or she is doing. You have to be careful of physicians or experts who think they know what you're doing better than you do. It's your obligation to prove something at some point either to the judge or the jury. You know the elements of your claim and how to get at them. You don't need a neurologist telling you how to ask a question or what the jury really wants to know. Your job is to know what the jury wants and needs and has to have and to get the expert to report those facts.

Make sure you understand the anatomy. That's one thing that working with an expert will allow you to do. You will understand what the hemothorax is, and you'll be able to explain it in a way that a lay person or a judge will understand. I've found it helpful if I can explain something, and I'm not a physician and didn't go to medical school or take anatomy, but if I can explain something at home to my wife or to other people in the office, then I can explain it to a jury. If I can't do those things, then I don't have any business asking questions of a doctor who's going to be testifying because I'm really not going to understand what he or she is saying.

Don't be afraid to legally guide your expert. Often, when an expert report is first written, it's a draft. The doctor or the expert will ask the attorney if all questions raised by the attorney have been answered. In working with the expert, I'm not telling the expert what to say, I'm just making sure my questions are answered. I know from working with Jasen on occasion, that he's been asked to say things he doesn't believe and that he will not do so. You don't really want to do that with your expert. If your expert doesn't believe what he or she is saying, it's going to come through. The jury is going to see it and sense it. You want your witness to be sincere and believe what it is that he or she is testifying about.

The one instance I was aware of with Jasen, he refused to be a witness for that fact. In fact, he stopped doing work for them. I think that's probably helpful in terms of reputation. Ultimately, it doesn't serve a case to have somebody come in to say something that he or she doesn't believe. Sometimes it may work, but my sense is that judges and jurors sense that that doctor really didn't believe what he or she was saying.

Sometimes the experts are sophisticated about the legal issues and they know how to count sheep with the things that they say, but sometimes they don't and you have to make them aware of legal issues. You have to know that sometimes the rules in states are different. What you are saying in New Jersey may not be good enough in Pennsylvania and vice versa. For example, does the doctor need to say that A caused B, or does he or she need to say that A increased the risk for B to happen? There is a difference in those things that sometimes can make a difference whether that doctor ultimately gets to testify or gets to put that opinion to a jury.

When getting ready for the witness to testify, I almost always will meet with him or her in advance, sometimes a week or two before, sometimes longer than that, it depends on scheduling. But I sit down with the witness, and I go through what it is that I'm going to ask him or her to make sure the witness is comfortable with what I'm trying to get at. But also the witness can help me with which direction he might go with the question. Oftentimes what we do is go through it, and the doctor knows what I'm going to ask, and I know what the doctor is going to say. I try to anticipate where the other side might be going so the doctor doesn't get surprised. Sometimes I have to go back a second time because the doctor just didn't like the way the testimony was set up or I didn't like the way the doctor was approaching it, so we'd go back a second time.

What we really want to get to is the point when the doctor or expert comes in to testify, and he knows what I'm going to ask, and I know what the doctor is going to testify about. That's no different than any other witness you have at trial. You want to make sure they're ready. I want to make sure the doctor understands what point I'm trying to make and how I'm trying to get there, because sometimes the doctor will have some suggestions to help me.

It's usually helpful to remind the doctor about a reasonable degree of medical certainty or a reasonable degree of professional certainty if it's not a physician. Sometimes they know about those things and sometimes they don't, but you don't want to take for granted that the doctor, even if he or she has testified on many other occasions, really understands what this is all about. I've found over the years, at least from my perspective, the choice of the physician to perform an evaluation or examination really tells me where the case is going.

I'm sure you all know that on both sides, there are doctors who will say anything. You'll get a notice that Dr. so-and-so is going to perform an IME, and you'll know that the doctor was chosen with the idea that he or she was ultimately going to testify in front of a jury. The lawyers know that the opinion is worthless, the judge knows that the opinion is worthless, but the doctor is going to testify. Some doctors are very good. Some aren't so good at testifying. Some are very convincing, and some are not. You can often tell when you see the same orthopedic surgeon who doesn't practice anymore and just examines people for insurance companies. He's not there to provide an independent opinion. He's there to provide a defense opinion.

I was asked recently, would I want someone with good credentials or a good performer. My first thought is often you can get both. If you can't get both in the same person, I would take the good performer. Credentials seem to sort of sound the same. Doctors have CVs that run onto 40 pages, and oftentimes, the opponent will stipulate to the witness's qualifications so that the jury doesn't get to hear all of that stuff anyway. So if you have somebody who looks and sounds pretty good and is sincere about his or her opinion, that's the person I would go with.

Make sure your expert is aware of whatever the problems might be with the case or the patient or client. We want to avoid surprise. Oftentimes, the expert can help you with that and point out where a problem might be coming down the road. You may want to make sure you can qualify your witness. I haven't had it happen to me, but it's happened in trial to opponents. They can't get a witness to qualify, and it's most devastating. To bring in a witness and go through all of the elaborate steps, and then for one reason or another, the witness isn't qualified to testify. The witness, then, in front of the jury, has to get up and leave because he or she isn't qualified. Another thing that happens sometimes is that experts want to say or do things that really aren't in their reports, and their reports, as you know, really are the basis for the testimony. We had a case a few years ago with an orthopedist, and he wanted to explain the mechanism of the injury. He brought in this little skeleton, and he carried it up to the witness stand and started testifying. At some point, the question was asked about the mechanism of the injury, and he said that he'd show us. He opened his bag and brought this skeleton out and started to talk, and the judge immediately told him to put the skeleton back in his bag. The jury was wondering why this guy brought this skeleton. Make sure that whatever you want your doctor to be able to say you are going to be able to get it in.

You need to be aware of vendettas or acrimony among experts. In one case that an expert testified for me, the other side had hired his former boss because they knew there were some ill feelings between the two of them. It really didn't come out when my doctor testified, but it really came out when the other expert came in to testify. They tried to make a big deal out of the fact that my expert had once worked for this guy. In comes this other doctor who tried to demean my expert because he used to work for him, saying that he's not as good as him because he was his boss. Don't ask the witness to say something he or she doesn't believe.

A question also occurs every time one of these IMEs is scheduled, and that is who goes with my client to the IME? You really have three choices as a plaintiff's attorney: you can go yourself, you can send a secretary or somebody in the office, or ideally, you can take somebody along who is qualified and understands what's really going on. Among the friendships that you might develop, you might have somebody who is a nurse or has nursing training. Usually, I go. Occasionally, that promises to be somewhat embarrassing depending on the nature of the illness or the kind of examination that takes place. I always ask my client if they care if I'm there or not, in advance. Sometimes the client says yes.

You can get somebody else to go along. I think having somebody there serves a couple purposes. One, you keep the examination more honest. You can keep time, you can follow the history, you can record what kinds of examinations are taken or performed, etc. I've been to at least a couple of these examinations where the doctor takes all of these measurements and performs all of these different things and takes not one note. Then, a month later, I get an 18-page letter, and I don't know where all that stuff comes from. But it's very helpful during cross-examination to ask a doctor where their notes are for this examination, because you know he didn't take any. You also ask how long they spent doing these things, and you know because you were there.

You don't necessarily need someone to testify that what the doctor says is not true because your client was there. If you need that kind of testimony, you can probably get it from your client. I think I mentioned flexibility with the expert. It's something that you want to know about in advance; that he or she is able to work with your schedule. Lastly, there has been some discussion about records being sent to experts, and I have found it helpful to put all the records together. I do it reverse chronologically, and I divide it by provider. But I number all of the pages, 1 to

140. Deposition transcripts are already there. I have a table of contents, too. Sometimes the records that get sent to experts are stacks.

It's really not fair to ask someone to go through all of that stuff and figure out what's really important. What I try to do is, I have a notion of what it is I'm after and what I think is important, and I let the doctor or the expert know that, but here's everything. So you have the hysterectomy 15 years ago on the bottom and you've got the most recent surgery on top, and somewhere in the middle there is what's really important. If you can help your expert get to that quickly, you're going to save yourself a lot of time, effort, and money.

I usually provide a summary. I try to ask questions of the expert when I do it in writing as objectively as I can. Doctor, this is what I need to prove. Can you say that A caused B based on this? Again, whatever I put in writing is going to end up being read by the other side and, if not in advance to trial, at trial. So whenever you put things in writing be careful and be cautious just like someone is looking over your shoulder to read it. Be as helpful and considerate as you can for your experts. They have other things to do. The more helpful you are in letting the expert know what questions you want answered, they are grateful for it, because they do have other things to do that are important. Thank you.

The Role of the Forensic Psychiatrist in the IME Process

Timothy J. Michals, M.D.

What I am going to do is to tell you how I got here doing IMEs. To be a physician, you have to go to medical school. I'm a graduate of Jefferson Medical School. I went there from 1962 to 1966. So I started 40 years ago. The context curriculum in medical school has really not changed a great deal with regard to what the format is. That is, medicine has just blossomed and exploded in what we already knew in the last 40 years plus.

Basically, what you do for the first two years in medical school is learn basic sciences, anatomy and how the body works, physiology, microbiology, pharmacology, and then the last two years, you learn clinical skills. That is, you learn about medicine, internal medicine, pediatrics, surgery, basically going into hospitals with senior physicians and staff to really see how it's done. There is a statement in medical school: You see one, you do one, you teach one. That's the learning format.

I've been an associate of Jefferson forever. I'm the director of the Division of Forensic Psychiatry and on the volunteer faculty there, and I've been there for my whole career. The usual contact that a medical student has for a house officer, who are residents, basically with medical legal issues is the issue of medical malpractice. That's a taboo, meaning that a physician is being sued because they are negligent in their care and treatment of a patient. So most physicians don't have many good words to say about lawyers – except for defense lawyers who defend them, of course. There's a bias that many physicians have with regard to their interaction with the legal system. Up until this date, there is very little in a way of teaching about legal issues in a curriculum.

When I did my training, I was an intern. There is no longer an internship now. It's called PGYs, post-graduate years. In psychiatry, there's four years. Basically in medicine, there's four years as well, and surgery goes up to six years, neurosurgery – there's a lot to learn in clinical experience.

Currently, what I'm doing at Jefferson is teach the PGY 2s, the post-graduate year IIs. I teach them eight hours a year of medical/legal things that they should know, and primarily what I teach them is medical records. Basically, medical records are the most important things a physician can have. Documentative thinking is their work product of what's going on. Basically, the course teaches them how to document what they've done. Their appraisal of the situation. I also have, currently, two fourth-year residents who spend a day with me a year. They sit in my office and see what I do. Some individuals have an interest in forensic psychiatry.

When I did my training, I took training in forensic psychiatry in the psychiatric division of the Court of Common Pleas in Philadelphia County. That was a criminal court experience; Temple University Law School ran that clinic. There was no availability for any training in civil matters. What has happened is that there has been an organization called American Academy of Psychiatry and Law that's grown and grown and has several thousand members now.

There's a senior forensic psychiatrist in this area, and I'm probably number two in the area here. So my experience with regard to forensic psychiatry in civil matters really came from professional organizations. I was involved in a murder trial a few years back in Scranton County. The defense attorney was a very capable trial attorney. At one point during the trial, when I was testifying, there was a bomb threat. The whole court was evacuated, and the District Attorney believed it was the defense who called in the bomb threat because he was falling behind. Let me say something about the American Medical Association (AMA) besides they are a professional organization. What that organization does is set standards for medical education. Basically, every medical school has a curriculum, and it has to be approved by one of the accrediting bodies of the AMA.

There is a second organization that deals with specialty organizations. In psychiatry, it's the American Board of Psychiatry and Neurology. What is set up there is criteria for testing, as well as criteria for residencies. So it's important that these organizations, besides being professional organizations, get very important criteria for what we do.

Getting back to my experience, I've basically had some training in criminal matters, but there was little available in civil matters. I've been doing this now for 30 years. I completed my training in forensic and clinical psychiatry. What has happened since that time is there has been a growth in forensic psychiatry and a lot of information in the medical literature, and there's a lot of interest in forensic psychiatry. Certainly, the Andrea Yates murder trial is a high visibility trial and, unfortunately, brings a lot of human drama through the attention of the media. Also, what's happened is there are a lot of people engaging in forensic psychiatry, psychiatrists who really have little or no training. I think that that, at times, is really a disservice to the people who are represented.

One of the things that I would recommend when talking about a reasonable degree of medical or psychiatric certainty, asking your expert, what does that mean. Basically, there are legal criteria as to what that means. It would be nice that when someone says, "I express my opinion with a reasonable degree of professional or psychiatric certainty," that the person understands what they are talking about.

Forensic psychiatry is a sub-specialty of psychiatry. Each sub-specialty is concerned with human behavior. Each sub-specialty has developed a subtle institution of procedures, values, and vocabulary. So in forensic psychiatry, it's important to have a sense of what the psychiatric medical issue is as well as what the legal standard is. There have been two boards with forensic psychiatry, initially the American Board of Forensic Psychiatry was an offshoot of this other group, The American Academy of Psychiatry and Law. Basically, you had credentials as you did for any training.

You were tested with a written test. It was quite challenging. What that group has done now is conform it into the American Board of Psychiatry and Neurology, and they have a test. As of this year, if you are going to take that test, you need to have a one-year fellowship in forensic psychiatry. You have to complete your training in four years, and you then have a fellowship in forensic psychiatry. Along with a colleague, I had attempted, several years ago, to develop a forensic psychiatry program fellowship here in Philadelphia, using all of the medical schools, where there is a great wealth of information and a lot of resources. But unfortunately, because of financial restrictions, we weren't able to do so.

How do physicians get involved or how can they get involved in medical legal matters? The American Medical Association has something called a council on judicial affairs, and they print out publications. The publications are called The Code of Medical Ethics, and 9.07 deals with medical testimony. It states that as a citizen and professional with specialized training and experience, the physician has an ethical obligation to assist in the administration of justice. The patient has a legal claim to request the physician's assistance, and the physician should provide medical evidence with the patient's consent in order to secure the patient's legal rights.

Medical experts should have recent experience before they testify and should limit their testimony to their sphere of medical expertise. Medical witnesses should be adequately prepared and should testify honestly and truthfully to the best of their medical knowledge. Medical experts should not be an advocate or a participant in the legal proceedings. The attorney calls the physician, who should be informed of all favorable and unfavorable information developed by the physician's evaluation of the case.

It is unethical for a physician to accept compensation that is contingent upon the outcome of the litigation. That raises an issue with me. If a physician is treating somebody, what is their take on the situation? To get paid. They are getting paid for their service in the situation. We psychiatrists then get billed for our time. I think that it's a potential conflict of interest for a treating physician to be an expert witness. There is an article in the handout that deals with this duality, and I'd like to talk a little bit about this.

When a physician is treating a person, basically, they are there to evaluate, diagnose, and relieve the pain and suffering of a patient through treatment rendered. Treating physicians enter what is called a therapeutic relationship alliance with the patient, and in most cases, they accept what the patient says to be so. Certainly, if the patient came to the hospital with chest pain going down your arm into your chin, the physician would think that that might be a cardiac type of phenomena. The treating doctor is not going to question that person. They're going to go ahead.

The same thing occurs in psychiatry. There is little in the way of questioning about the accuracy and reliability and validity of the person. As a treating physician, you accept that to be factual. Many treating physicians sell themselves short by just getting the information from the patient. There are medical legal consequences to that. There are a number of cases in which a person or patient goes out and harms somebody, and the doctor has failed to get previous records in which there has been a documentation of dangerous behavior. As a result of that, physicians should sue because he should have known that information.

Routinely, in every person I see that I treat or evaluate, I want to be as informed as I can be. So I request medical records from everybody. I want to be knowledgeable in that sense. What happens if a physician is not getting paid? They are seeing the person and for whatever reason it is, the insurance company is holding the claim, or not paying, and after a period of time they have a bill of several thousand dollars. That may be looked at as a contingency fee. They're receiving payment for those services may be contingent upon the successful outcome of that case in favor of the plaintiff. If that doesn't work out, they aren't going to be a happy camper. They are going to be stuck, and it's highly unlikely that the patient is going to be responsible and pay.

Worse than that is that litigants who lose cases aren't happy. What may happen is that if a treating practitioner testifies and become an expert and they don't do a great job, the plaintiff or litigant who lost this case may be angry and may take it out on a variety of people, including his counsel as well as the treating practitioner. That is when we think that a doctor can't serve two masters. Generally speaking, if I'm asked to treat a patient, I'll treat the patient, but I won't try to testify as an expert. I think that there is a potential conflict.

There is an article in your handouts that deals with this matter. I've given you a copy of a report. My reports are all the same. There is a protocol that I use. If you look at a thousand of my reports, they are all going to have the same protocol. I've learned that through my training and experience.

The first thing that is required in any forensic evaluation is obtaining informed consent. What that means is that the IME physician informs the individual examined who they are. For example, "My name is Dr. Michals, and I've been asked by Mr. A, B, or Z or this company or whoever to do this evaluation. I'm here and I'm not going to treat you or be your doctor, and I'm not going to tell you anything. If I do tell you something, I have entered into a doctor/patient relationship. When I make recommendations in my report, if I tell you something, I've shifted gears. I've gone from an evaluator to a treater." So I inform the individual that I am not doing that. I also inform them that what we talk about is not confidential. It's not between us because I am going to send a report to whoever asked me to do this, and I'm also at a potential to be called to testify. That's the first thing that I tell them and then I ask if there are any questions. If there are questions, or they don't understand that, or if they say they want to talk to me with an attorney, they have a right to do that. This is a serious matter for all individuals who are involved. I'm just a medical expert doing my job here. This is their trial, their case, their life. So they have a right to do that.

The next thing I do routinely is try to get a sense of what the patient's current medical management is. I'll ask them, "You're on medicine A, B, C, or D, who's treating you?" I do that for a couple of reasons. It gives me an understanding as to what the medication they're taking is and how it affects their presented state.

In medicine, there is a format. The doctor takes a history, does an examination, does studies, and based on the composite of those findings, they arrive at a diagnosis. The diagnosis is the basis of the treatment that the

physician render. I recently saw an individual who had seen a psychologist on a weekly basis for five years. She also had seen a psychiatrist for four years, and for the past four years had been on 60 milligrams of Prozac. She still claimed to be symptomatic.

There is something called treatment guidelines. That is just what it says, it's a guideline, and basically something to consider in all doctor/patient relationships, use your clinical judgment. There's a *Physician's Desk Reference* that tells you about the medications and what they are used for and the indications. In medicine, per se, medications are used for many more indications than are in the PDR. It's based on the medical literature, the scientific information that we know. But there have been some guidelines by the Agency for Health Care Policy and Research, which published clinical practice guidelines for the treatment of depression. They state that these guidelines recommend that anti-depressant treatments are given seven to twelve months for treatment of first, and some second, episodes of major depression.

By getting the information from the patient that they have been on Prozac, 60 milligrams, for four years and are still symptomatic, something is not working right here. Basically, most people with illnesses fortunately improve with proper treatment. If a person doesn't get better, what the treating physician must do is say, "Am I making a proper diagnosis, or am I on track here?" The second thing is, "Am I treating the person appropriately?" If the person hasn't gotten better with the treatment in five years, make a change. We have a zillion medications. Certainly, one of the questions that would arise if this went to trial would be, "Dr. Jones, well, you've treated this person for five years with medication, why didn't you change it? Isn't that a reasonable thing to do with all of the medications available?" So I try to get that information up front, not only how much they take, but how long they've taken it, to get a sense of what the situation is.

The next thing I do is say, "Tell me your story." I want to learn about their problems, if it's related to an injury, whatever it is. I want to learn their history and their story. When I do, I really ask basically open-ended questions. I don't use questions that are suggestive. You don't have to be a genius to figure it out, and most people I think are very credible. I think most people are honest and forthright, but there are others who aren't. So I don't want to ask questions that may suggest symptoms to the person that I am evaluating. I want to hear their story, rather than suggest or ask questions that may lead them one way or another.

An IME is really the opportunity for a person to put their worst foot forward. Basically, tell me the story and all the gory details. What's wrong with you, I want to learn that. The history is important. We know in medicine that there are certain pathways that disease processes follow. We want to see if this occurs. We want to see what sort of treatment occurs and if there is responsive treatment. If the patient hasn't gotten better in five years with the treatment, something should click there. Maybe they should get a second opinion. Maybe the doctor should send the person to somebody else and say, "I've been doing A, B, and C to this person, and they haven't improved." It's really not fair to the patient if the treating physician hasn't done their best to alleviate symptoms. The next thing I do after getting their story would be trying to get a sense of what's going on in their life, what's their background. There are some illnesses that have a biological, genetic nature. It's not uncommon that the illnesses run in the family, such as cardiovascular disease, pulmonary disease, and a variety of emotional disorders. Depression is a very common illness that may have a genetic basis to it. It's important to get that information and find out if they've been treated in the past. I'm amazed how often people aren't forthright in telling physicians the information. I would think that their attorney would tell their client that the IME doctor they're going to see is going to get this information and ask questions, and if they've been treated in the past, it's likely that the IME doctor is going to get records." Sometimes people may forget, that can be an honest mistake. Other people just may not tell the IME physician that information because they don't want them to know. When I do my conclusions, I say the following statements: "Based on the results of my clinical examination, the results of psychological testing, the review of medical records and reports, the history..."

If the history provided to the forensic doctor in an IME or any evaluation is not accurate, well, they may be off base there. It's important for the person who is being seen to provide an accurate and viable history. If they are holding back or aren't telling the physician about the fact they have been seen for a history of substance abuse, or whatever, it may have nothing to do with their injury or presented problems, but it looks bad. It just looks bad and is not helpful for that person. Certainly, if I were a lawyer or a plaintiff's attorney, I would tell the person to tell the truth. Because what I'm going to have to do as a forensic expert is tell the truth because it's possible I could be called to testify on my findings, and I'm sworn to tell the truth.

There is a recent article that I would like to tell you something about. The author is a psychologist and professor of law at the Penn State University. He's a very active writer. He brings to our attention that in addition to the American Academy of Psychiatry and Law, the following professional organizations discourage treating physicians from becoming experts: the American Psychology Law Society, the American Board of Forensic Psychology, the American Academy of Psychiatry and Law, the Committee on Psychiatry and Law, and the American Psychological Association.

There is an article written on this. The authors say that therapists are usually highly invested in the welfare of their patients and are rightfully concerned that publicly offering some candid opinions about the patient's deficit could seriously impair their patient's trust in them. They are often unfamiliar with relevant law. They are often unaware of much of the factual information about the case, and much of what they know comes solely from the patient and is often unconfirmed. What they do know, they know primarily, if not solely, from the patient's point of view.

If I'm treating somebody, I'm in a relationship with that person and I wish them the best. There is an intrinsic bias on my part for my patient. In an inquiry to the Committee on Ethics at the American Academy of Psychiatry and Law, the psychiatrist states that he is treating an insurance company employee for the past several years who has been forging signatures on loan applications and running an illegal scheme at work. On two occasions, he has been admitted to the hospital because of stress. The physician will be testifying in a workers' compensation hearing regarding the employee's ability to work and asks if he is obliged to reveal these illegal activities as one major source of stress? This guy's in trouble. The doctor is in trouble. Why would I treat someone who is committing a fraud? One of the things that most relationships need to work is trust. Basically you've got to tell me these things, but a person who is involved in criminal activity is not the most trustworthy person in the world. I would be reluctant to come and talk to this person if he were my patient. I may have to say, I couldn't treat you. I may have an obligation, if you're committing a criminal activity, to report it. Current criminal activity, you have a responsibility for. Things in the past that people tell you about, there is less of an obligation to report that. So this doctor is sort of naive, I think, about what a doctor/patient relationship is and what psychotherapy is and what trust is. This is not far outfield.

I look at a lot of records, and I see information in records that are disastrous: kids having troubles, wife having troubles, other medical problems going on that are really significant and documented that would impact anyone. However, those problems are not considered by the treating doctor because they want to help the person. I think that's short sighted. Let me give you another illustration. In the case of Lyle and Eric Menendez, who were charged with murdering their parents, there was an audiotape of the therapy session in which Lyle explained why he and his brother killed them. During the penalty phase of the retrial of the brothers, the psychiatrist who had treated Eric and who also served as the forensic psychiatrist said, under oath, that he had altered notes of sessions as requested by the defense attorney. Among the most important deletions was a statement by Eric a week before the murders that he hated his parents and that he "wanted to kill them." Other deletions related to statements regarding Eric's homosexual contact and incestuous relationship with his mother that was "in his head." This is a travesty.

Certainly, I would think that the attorney is doing harm and the doctor, in his hope of doing good, is doing harm. What he was doing was really not telling the truth. He was withholding the truth from facts. I don't see myself as being an advocate in these matters. I'm just a psychiatrist, an old forensic psychiatrist. I come in here, and I tell you my story. I tell you what I've learned through my professional training and experience and what I think about this person. I'm under oath, and really what I have is my reputation. That's what I am there to relay. I don't see myself as advocating. Certainly, I've testified several times, and I have an understanding of the role of testifying. I understand, I think, what my role is and how I should answer the questions. There should be some obvious direction in questions both on direct and cross examination, and certainly when I evaluate someone, I consider the options. What's the opposite side of this page and what may I be questioned about on cross examination? So I am prepared for that and certainly when meeting with an attorney prior to testifying, that's their responsibility to bring things to my attention. I always recommend that if there's any difference or there's something new in case law, that the attorney should bring it to the attention of the IME doctor. That's their job. We should be informed. We are not lawyers. We are just doctors. We should be aware of what the medical legal issue is that we've been asked to identify.

I certainly find it very helpful when I am seeing someone and there's a lot of records, if there is a list of what these records are. That they are outlined is very helpful to me. It helps me with my organization with regard to giving my report. One of the things that I think is important to be aware of is that professional organizations such as the AMA have requirements, that is continuing medical education. In Pennsylvania, you need 150 hours of CME credits every seven years. Same thing with American Psychiatric Association.

You need to have that updated information. I probably receive 15 journals a month, and it's a ton of information in that. I don't read it all. I can't read it all. But there is certain information that you should be informed of. So getting an expert or a doctor who has an ongoing involvement through an education, I think is very vital. They are informed and they are current because the pace of the change is really amazing.

In my draft report that I have, in the opinion I tell you what I think is going on. At times, I am a little more comprehensive in my documenting my thinking, and other times, I just give opinions. That really depends on me or what I am asked to do. In many situations, the report is the end product. That may be the basis for resolving this litigation. A lot of cases are settled. I never know that. I do my work and maybe I go to trial. In most cases I'm not aware of the outcome of the litigation. Frankly, I don't care. I'm not invested in that. Sometimes a person will call me and let me know what's going on and that's nice to know. If you testified, it's nice to know that the person thinks you've done a good job or you haven't done a good job. But basically, the people or principal players – the plaintiff, the defendant – this really impacts upon them. This is not my case, this is their case. I'm providing an independent medical opinion concerning what I know about this area.

I do address certain issues concerning if I do find an illness, and frankly there is frequent illnesses related to the issue in hand. It's a work-related injury when a person falls from 15 feet and hits their head and they're in a coma, things like that. The expert wants to find out, is this a product. Is there an issue of causation here? I find it very helpful to look at medical records pre-litigation. If a person has sexual harassment at work and goes to an emergency room because they are very anxious, and they have a panic attack and anxiety. There's all sorts of physiological things that go on. It's the same as fear, but fear you know what you're afraid of. When you have a panic or anxiety attack, you think you might have a heart attack because it involves the cardiovascular system or you think you may be going crazy in some situations. I find it interesting to look at those records and to see what the vital signs are.

a person is really anxious and having these symptoms, there should be a correlation between their subjective complaints and their symptoms and how they are responding. I would want to see or I would think there may be some elevation in their pulse or respirations there. The person comes into an emergency room after having a head injury of some sort, what are the complaints? These are neutral individuals. They are there to treat and evaluate the person. If at some point down the line the person says they have cognitive problems, they have headaches, they have all these things, but I go back and I find that the emergency room physician, the nurses don't document that information. As a matter of fact, there's no evaluation at the head or brain, there's no studies, MRIs, CT scans, whatever. These individuals cannot wait on that.

When I testify, I often say the records and the opinions of the treating physician before they get involved in litigation is very important factor for me to consider. Records are very important; what they do say and what they don't say. I routinely administer a test, a psychological test called the Minnesota Multiphasic Personality Inventory to people I see. I do this for a couple of reasons because it's a psychological test and an objective test. It consists of 566 statements, and the examinee is instructed to answer the statements mostly true currently, mostly false, false. It tells me something about their emotional state at the time of the evaluation and about their personality traits, longstanding and developmental. That is, we become who we are as a result of what we are born with biologically and our life experiences. That's our personality and our character. You can learn something through this test.

It also has what is called validity scales. What that means is there are questions with three different scales that will tell you whether the person is failing to admit any psychological shortcomings or they are "faking good." Some people "fake bad," they are off the charts with what's going on. Other people have valid profiles, which they are open with. I use this, and it provides me with vital information other than what the person is saying. There are a whole number of tests that can be done and in some cases, should be done. Certainly there are diagnostic imaging studies of the brain for people who have head or brain injuries. There is neuropsychological testing. So it makes sense that if a person has symptoms, what one would expect would be an appropriate evaluation of the

symptoms to see if anything is going on. I don't like finding that it's all in their head and they have a brain tumor up there rather than some emotional complaint of depression. It's important to get records to see what has occurred in the past and to correlate your findings with your examination and what is found on testing as well as what's found on past medical records.

I think the function of an independent medical expert is to be independent and to be an expert. You should get your money's worth. Basically, you should be comfortable with the feeling that the person who is doing this examination is taking it seriously, has done a thorough job, and is a person who can communicate. A lot of doctors don't want to do this work and a lot of doctors did this work for financial reasons, I think. Especially with the dramatic changes in healthcare compensation now, the HMOs wreaked havoc with a lot of things and, certainly, with doctor's incomes, but I think also with access to treatment for patients as well. And there have been people jumping in who have little training as a way of augmenting their income by doing these evaluations. At times, I've seen some people do a great job, and at times, I've seen disasters. I think they shot their clients in the foot. They haven't done a service, but a disservice.

The last thing I'd like to talk about is a publication that's widely used in psychiatry. It's called The DSM Fourth Edition, it's TR, text revised. What that is is a publication by the American Psychiatric Association of mental disorders. Its purpose is for treatment and for research. If you look in the front of that book, there are some rules of using this in forensic settings. It's not to be used as a cookbook, and it's not uncommon for me to see reports and probably the most misdiagnosed, over-diagnosed condition is post-traumatic stress disorder. I'll find a report saying that Mrs. Jones meets the following criteria for PTSD, and these are all subjective complaints.

Basically, the first thing is handling life-threatening trauma. September 11th has brought this to the forefront. Two recent articles in the *New England Journal of Medicine* found that 8 percent of people have post-traumatic stress disorder and 12 percent have depression from 110th Street to Canal Street in New York by a study by a variety of people. We do know that in 50 percent of the time, within three months, people with post-traumatic stress disorder improve with appropriate treatment. So this is a publication that is a guideline for treatment and research. It's frequently used in litigation. It's widely used but it changes all the time because you learn and things are taken in and things are taken out. Lawyers go through it, and this person claims this and that. Therefore, they have criteria for post-traumatic stress disorder. We all may have criteria for a variety of these different clinical conditions, but fortunately we do not have them. So let's composite not only what the person is saying, but do they have an illness.

One of the features in forensic psychiatry is if you do have post-traumatic stress disorder, in fact, when you live the experience by talking about it, it reactivates the experience, the emotions, and the thoughts of it. It's like the VCR is set off in our brain again, and you feel frightened. You're upset. People who have this, when they talk about it have an emotional response to it. People who don't, who have been effectively treated, when they talk about it, they are not anxious. They are not upset, so there is a disparity between what they are saying and what you see here. That's important from my standpoint as a forensic medical expert.

What I've attempted to do is tell you a little bit about how the medical education has to do and what it doesn't have to do with medical legal issues. I think there's been some change here. There's been a real growth in the interest and the information in forensic psychiatry. There are stand-up protocols, and there's all sorts of testing that can be done that is very helpful in evaluating people. There are actual studies that are based on statistics that tell you something about people rather than a clinical judgment. It's important to use all of these things and be comprehensive.

I think it's important to be honest to yourself, honest to the medical legal profession, and honest to people that you see. I think that if you do that, then you've gotten what you should get from the IME. Thank you.

Assessing Pain in the IME

Wilhelmina Korevaar, M.D.

My name is Wilma Korevaar, and I'm an anesthesiologist. My sub-specialty area is pain management. I'm going to talk to you this morning about assessing pain in the IME. First, I would like to say a little bit about what got me started doing IMEs.

My background is in anesthesiology. I did work for a while as a pediatric anesthesiologist and internist, and then in the mid-1980s, I went to the University of Pennsylvania. I had also done a Pain Fellowship, and in the mid-1980s, there were no Pain Clinics in Philadelphia, and there was no place that friends of mine with things like pancreatic cancer could get intervention for worthwhile treatment for pain relief. It was before the advent of long-acting narcotics, and since I had done a fellowship in pain control, I thought this is something that I should do because it doesn't exist in this entire large town filled with medical centers. After I started a pain service, my initial interest was in very aggressive (at the time) nerve block interventions for cancer. But of course I also collected patients with all kinds of other ailments including reflex sympathetic dystrophy (RSD), disc herniations, and so on. And they all wanted to be treated for their pain.

In about 1986, a year after I started this, I was treating somebody with RSD. I was extremely academic and very naïve at the time. I had not a clue about the medical legal system, and especially about disability. I was looking at this only from the standpoint of I want to do what is right for these people. Now you have to understand that one of the most important factors in recovering from a chronic pain condition is being able to resume normal activities, be they at home or at work. So I knew this young woman, she was coming along beautifully. She had a couple nerve blocks; she went to physical therapy; she was a good patient. She had objective improvement in how her hand looked. It was her dominant hand. She even went so far as to make for me a little tiny bear that she hand stitched, with this hand that was hurt. And so, the time came that she said, "Do you think I should go back to work?" And I said, "Of course, because it's going to make you even better. Recovery will be slow but over time, you will get better." I released her to return to work. She had the kind of job that, by her description, I thought she could do safely and that would, overtime, improve her condition.

To my amazement, I got a phone call and then a visit from an attorney representing her, who was outraged because I returned her to work because she had this diagnosis; she had high pain; how could I do this; wouldn't I consider rescinding that decision.

It took me several more years to really catch on to what was behind that request, but that's kind of what shaped the evolution of my career, in the sense that I still believe that people who have chronic pain need to get back to normal daily function; or they won't get well. I am still a physician. Even though I do IMEs mostly on behalf of the defense – I sometimes do them on behalf of plaintiff attorneys – in any case, I'm still a physician, and I still believe that these people deserve an opportunity to get well.

When I do an IME, I bring a person back to the examination room, and the first thing that I do, is I say: "I need you to disrobe and put on a gown for this exam." More than 50 percent of the time, the person I'm examining says, "Yes, but it's only my hand and my own doctor never makes me do that." I have to explain to them that I cannot examine somebody with their clothes on. When I'm trying to assess pain in an IME, it is to see whether there are behaviors, whether there are musculature asymmetries, and whether or not there are underlying medical conditions that can explain what is going on that can confirm or not the complaints of pain. So, it's not possible for me, anyway, to do an examination without having someone disrobe.

Also, I am constantly amazed by the number of times that advocates for the patient come along and sometimes their attorneys – whom I actually like the most because the attorneys are most polite – but other times they are not, and they are told to keep track of time. How long does she ask questions; when does she do this; how long does she spend doing that. In a sense this drives me nuts, because from the minute I walk into a room, I'm actually examining a person. I'm looking at the color of their skin; I'm looking at how the skin looks, do they look healthy; I'm looking at how they actually use their hands, do they climb on and off the table; how they sit; do they appear comfortable. All of those things are objective pieces that eventually I will try to put together with what is told to me and what is in the record to come up with a reasonable explanation or diagnosis for the condition.

I begin by asking questions, and the first questions I try to ask are about mechanism of injury. Sometimes I'm precluded from really understanding this because there is a fine line between questions that go to liability in third-party cases and questions that purely relate to how were you injured. It might be the case when I'm saying, "Well in this car accident, what happened," that the advocate may stop me and say you're not allowed to ask that. To some extent that is correct. I have to ask it in a way that I come to understand what happened to this person's body at the time of injury. I need to understand whether there was bruising, swelling; whether there were broken bones;

what body parts were affected. I need to understand this from the moment of the injury and as it evolves overtime, especially early on.

Later, after the history and physical examination, I will then go to the record to see what is in the record. It's amazing how, over time, people's perceptions of what happened change. A recent example is a woman who fell in a bakery; she had a slip-and-fall. Initially, she just fell down on her buttocks. She went to her doctor a couple days later complaining of diffuse back pain. By the time I saw her, it was two years later – that's unfortunately when I see these people – and what she told me was that she had right-shoulder pain, and this happened because when she fell, she fell directly onto her right shoulder and did not strike any other body parts. That tells me that she is under the misperception that this shoulder is only going to be included if she somehow goes back and says I did this impossible maneuver.

The next thing I want to know verbally from the person is, "When did you start having the pain you now have?" because there is often a difference. Again, there are situations – and we'll get into detail very shortly about this – in which a particular character and quality of pain should begin almost immediately at the time of the injury. There are other situations when, as a result of guarding and adaptations to injury, a particular character and quality of pain develops. That is also important to help me understand what is going on. When I do an IME, I cannot put myself into the role of treating doctor, but I can try to structure my questioning in such a way that maybe for some of these people a light-bulb will go on, and they'll start to say, "Maybe if I don't sit this way all the time, I won't feel so bad." To start with, I like to believe people. When I graduated from medical school, my advisor accused me of being much too realistic. He said that you really can't believe everybody. But for me, I need to in order to get through the evaluation; I need to believe that what this person is telling me is truth. As a consequence, I'm also frequently disappointed when I get to the medical record and find out that they didn't tell me the truth, but I would still rather approach an examination from the perspective that this person has pain and that they are believable.

During the history portion, I want to know about what kind of pain it is: does it burn; does it ache; does it throb. If it burns, it's more likely due to a nerve problem. If it aches and throbs, it's musculoskeletal or joint. Those are not absolutes, but they are nice rules of thumb when you're trying to understand what someone is telling you. I also want to know what kind of impact this pain has on life activities: how do you spend your time. Of course, we all know that we have good and bad days; so I want to know what you do on your best days and what you do on your worst days.

Remember that as I'm asking people these questions, I'm looking at them. If it's the summer and the person has a nice suntan and tells me that they are inside all the time, the next question I will ask is: have you been on vacation; have you been to the shore. Later, during the physical exam, if I see actual swimsuit strap marks or something like that, I will ask one more time: how do you spend your time, what do you do. "I'm inside on the sofa watching television." If I'm looking at the person when I'm asking about impact on activities, and they say well "I do sit outside on the porch," and I say, "Does the porch have a roof," and they say, "No, I sit in the sun, it feels good, it feels warm." When I'm looking and I'm seeing dirt under the finger nails and seeing hard callous on the palms as they move around on the table, then I'm thinking, what else are you doing when you're sitting out on the porch, "whittling decoys..."

Most people don't catch on even though I repeat the question several times, and like Dr. Michals, I don't like to put things into their mind. Then this turns into sometimes contentious questions during that position. I won't say to someone, "Well, but your hands look like you're doing more than just sitting on the porch," and their attorney will later say to me, "Well, why didn't you ask," and the reason really is just that I don't want to putting things into people's minds, and also I don't think there's much point in becoming argumentative during the evaluation itself. The next thing that I am very interested in when taking a history and thinking about the pain, is the treatment course. What kind of treatment have you had? Have you had 500 nerve block injections with no relief? Have you been put on OxyContin and Neurontin in massive doses with no relief? Are you continuing to go to physical therapy everyday to get hot packs and ultrasound with no relief? Have you been on a rational treatment program with perhaps some benefit? There is nothing wrong with treatment programs that work; I'm a big fan of that, actually.

With regard to medication, there are some real issues. I see a lot of people, especially in the middle part of the state, who are on massive doses of OxyContin – they tell me they are – and huge doses of Neurontin. Now these

people sit on the examination table, exhibiting no rigidity, no tremor, no nystagmus, and they tell me they are taking these drugs. I have a problem with that because those drugs should produce objective findings when someone is sitting on the examination table. Later, when I do the physical examination, they should have excess reflex activity, maybe some cog wheeling, and most of them don't. Unfortunately, I can't get a urine test, and I really can't recommend periodic testing to evaluate whether people are really taking what they say they're taking or not. Even more unfortunately, I ask, "Well, what did you take today, and when did you take it?" If someone says to me "I took 120 mg of OxyContin (which is a lot) and I took 1200 mg of Neurontin," and this person is otherwise neurologically normal, then I really know that they didn't take that medication, but I have no way really to prove it. That's a problem.

Other things that have happened, include someone telling me they have had nerve block injections of a particular type, and I'm going to examine them and know that if you've had a particular injection within two weeks of an exam, you should see bruising and evidence of a needle puncture in a particular location. There are times where people will say, "Well yesterday, I had a stoic ganglion block." They should have a bite mark on the front of their neck, and there is nothing. That is something a little more objective that I can document.

I'm going to talk to you about the alphabet for a little while. I'm going to do this because the most frequent reason I'm asked to see someone is for evaluation to rule in or rule out reflex sympathetic dystrophy, otherwise known as RSD, otherwise known as complex regional pain syndrome Type I. In 1994, a group of international experts was convened, and their charge was to come up with a new way to describe RSD because RSD had lost all medical meaning. It was so overused in the medical/legal community. The preamble to the journal article clearly states that that was the reason for renaming RSD. The new name is "Complex Regional Pain Syndrome Type I." They are synonymous. If you look in the index of the latest AMA *Guides to the Evaluation of Permanent Impairment*, you'll see that they are synonymous.

Thoracic Outlet Syndrome (TOS) is another popular diagnosis. It actually is a problematic diagnosis if you look at the medical literature, in that most of the cases are called "disputed thoracic outlet syndrome." That means there are no objective physical findings to confirm the diagnosis, even though there may be surgery to treat it.
Herniated disc is otherwise known as herniated nucleus pulposus (HNP), a somewhat less popular diagnosis for chronic pain patients. Interestingly, you might think that if you looked in the medical literature, this should be the most common underlying diagnosis for the development of chronic pain. Finally, peripheral nerve compression, which includes carpal tunnel syndrome, another diagnosis that should be more rather than less popular.
The cardinal features, or requisite features, to make a diagnosis of RSD are varying pain, stiffness, swelling, and discoloration. What do I mean when I say that? I mean that those four things need to be present. The swelling may be of a greater objective magnitude than the stiffness at some point in the course of this individual's description in the record, and not coming and going, and not present on different dates; they are not additive. There are other features that go along with the burning pain, swelling, stiffness, and discoloration. Those essentially follow patterns related to the severity of the initial tissue trauma. So, for example, if you have a really big crush injury to a foot, you expect that the swelling and discoloration will last longer than if you have a simple small twist of the ankle. One of the features that's important is what is the time course: When does this start? Does this follow what you normally expect after a particular kind of injury or not?

One of the features of RSD is that the pain, stiffness, swelling, and discoloration extend well beyond the normal time course you expect. If you twist your ankle, you expect it to be sore, swollen, maybe bruised for three weeks maybe six weeks depending on how badly you twisted it. But then you expect those things to resolve, and if they don't, and they're getting worse, and if they're inhibiting weight down on the foot, then a diagnosis of RSD is reasonable. It occurs only 0.5 to 1% of the time after traumatic injury. It occurs much more often in the medical literature after heart attack or stroke – up to 20 percent of the time. It really is not a common diagnosis in the whole of medical literature.

The pain of RSD does not respond to narcotics. This is important. So why should anyone with RSD be on OxyContin, which we know is a dangerous drug, which we know is habit forming, and which we know in and of itself has side effects and downside risks. The pain does prevent mobilization of the limb after injury, and that's because downward pressure on a palm or a sole increases the pain, which is a characteristic feature of RSD pain, and it is called *allodyna*, a word I am sure most of you have seen in records. Over time, the objective physical findings change and they reflect two things: the underlying pathophysiology or altered blood flow and disuse of the limb

because it hurts; it hurts to have anyone touch it; it hurts to put pressure on it. Remember, with a hand or a foot, extending the fingers or the toes and putting pressure are important pieces of functions. So, if that really hurts, and you don't do it, in fact, the fingers or the toes will start to curl up – just like you see in someone, for example, who has had a stroke.

You can do x-rays or a triple-phase bone scan, and you can see objective findings that will correlate with the clinical examination, but it is important to remember that this diagnosis is made on the basis of physical examination primarily. EMG and nerve conduction studies should be normal, and most people evaluated and treated early on respond favorable to sympathetic nerve blocks, not only in terms of pain relief but in terms of resolution of the objective findings. That's important when looking at a treatment pattern.

In a picture of two hands, one hand is normal and the other is a Stage I RSD, usually, one to three months after causal injury. Swelling, loss of extensor surface creasing, lose fist posture due to the allodinia. I want you to make particular note of the fact that this swelling is in the hand but there is no sharp demarcation at the wrist. It kind of disappears slowly up the forearm. I point that out because every once and awhile a person comes for evaluation and their hand is very swollen and there is a constriction area at the wrist or further up the forearm, and proximal to that or closer to the body from there is normal, and that is not RSD Stage I.

About six months ago, I had an attorney attach a picture of just that to a deposition transcript. He brought it up, he said, "Doctor, I want you to assume that this picture is of the person's hand after the injury," and I said, "I'm so glad that you brought this picture out, because it shows actually what I was trying to talk about when I was trying to discuss my examination findings."

With RSD, over time, things change. As I mentioned, that's a consequence of two occurrences, altered blood flow and disuse. So what you have is a malnourished limb that isn't being used. One hand has now atrophied between the thumb and the index finger in particular, and because of the swelling there is also loss of intrinsic muscles, the muscles between the bones in the hand. The hand is starting to change shape. Those muscles are responsible for keeping our hands in a normal shape. One of the other things that I am trying to point out is that RSD, like all post-traumatic chronic pain problems, is a problem associated with asymmetry. It is the hurt that develops the problem and looks abnormal.

Only about 5% of people with RSD go on to Stage III, because most people resume some function and therefore rehabilitate the hand to some degree, if not completely. Also, in the literature, there is no answer to the question, "Why do some people go on to Stage III?" because they may not receive early intervention and appropriate treatment.

I think over the course of the last 20 years, I've seen five people with Stage III. That's a very bad thing to see because those people really are not going to resume normal function of the limb, and so they have actually developed an impairment of significance.

Take an x-ray of the normal and the affected limb on one plate and compare. In RSD, there is patchy osteoporosis, meaning patchy loss of calcium of the bone, particularly in the area around the joints, and the joints are where the bones hook together. You don't see that in the normal hand. So this would confirm the diagnosis. This is also referred to in the medical literature as pseudo-atrophy.

Next, I'm going to talk to you a little about thoracic outlet syndrome. First of all, we all have two thoracic outlets, and they are at the base of the neck, above the collar bone. Their claim to fame is really that this is where the nerves and vessels to the arm run. This is also where the top of the lung can sit. So this is a very busy place, and you can also get lymph nodes in this area that signal illnesses in the thoracic or abdominal cavities. Now, it is not uncommon to see a diagnosis of TOS made after a shoulder injury, after an injury to an extremity, or for no apparent reason. It is not likely that only the nerves will be affected if indeed there is an injury to the thoracic outlet because it is a busy place and a lot of things are in there. The nerves are actually rather well protected and rather tough. So when considering this diagnosis, it is also important to look if there is evidence for injury to the large vein that returns the blood from the hand and arm and whether or not there is evidence or disappearance of the pulse, meaning compression or obstruction of the artery that sends the blood down to the arm.

There are tests that can be done; there is an absence test, where the arm is pulled back, the head is turned, and the pulse should disappear if there is a problem in this anatomic region. There is also the arm elevation rotation test, or hold-up position. Again, at the same time that the person says that he/she is developing numbness and tingling, the pulse should disappear.

There is a third test; the Roose test, named after the surgeon who had worked in Colorado (until he retired) and had done the most first-rib resections for TOS of anyone. He didn't think that it was necessary that there was any change in the pulse. It was only necessary that when a person did this, they complained. That was sufficient to remove their first rib. Why did he remove the first rib. This is also done in Pennsylvania sometimes, since he retired. These nerves run underneath the clavicle. So, the theory behind removing the first rib is that you make a bigger space for these nerves and therefore cure the TOS. Indeed, there are situations in which this would be perfectly appropriate. For example, if someone fractures their collar bone, and as it heals over time with a big chunk of calcium, called calcus, that actually is putting pressure on the nerves and causing evidence on objective neurologic exam for pressure and dysfunction in the nerves to the arm, then removing the first rib might be a perfectly reasonable thing to do. That person though will also have evidence for vascular obstruction to the arm on clinical testing, or even on angiography. This is a list, just to give you an idea, of where we would look to do testing with an EMG/NCS exam, for example, to confirm a diagnosis of nerve compression or injury in the thoracic outlet. You really should see evidence. For example, if you have a report from a neurologist and it says "brachial plexopathy, lateral and medial cords," you should be able to take that report and a nerve conduction test and show abnormalities in the musculocutaneous nerve and the median nerve, which are down among the forearm and down into the wrist and hand. You should also have abnormalities in the auxiliary and the radial. If your EMG/NCS doesn't figure this out, then you need to question that report from the neurologist as to veracity of the diagnosis. Here's another way to look at it from a more functional standpoint. If you're going to be talking about the posterior cord, you're talking about the radial nerve. You should see a deficit in the triceps muscle as well as sensory deficits down on top of the thumb. If not, then you need to question the diagnosis. It's not sufficient that the physical therapist who does the EMG/NCS says in his or her interpretation that there is this problem in the brachial plexus. The report should confirm that.

What about herniated discs? In respect to hands and arms, and I'm going to kind of stick with those because that's what we're talking about with RSD today (although it can occur in the feet). In TOS, the most common time that a cervical disc herniates is during sleep because if you think of the muscles and the outer surface of the disc, it's like a Chinese finger trap. When we're awake, our muscles and ligaments hold everything in place, but when we sleep, our muscles relax and we do move around. We may turn our head, stretch, and it may be at a moment in time when everything else is relaxed. A disc herniation is when the relatively soft inner portion of the disc squirts out between the fibers that hold it in place. A disc herniation is characterized in terms of pain by a burning sensation that may in fact radiate all the way from the neck down to the hand.

The herniated disc may be associated with true sensory loss in that same distribution – muscle weakness and reflex changes – but it may not be. This is one of the mysteries of pain related to disc herniation. Nobody really knows why you can have a situation in which you have terrible pain, and indeed dysfunction as a result of that pain, but no true muscle or sensory loss. It doesn't make sense anatomically because, in fact, if you look at how the nerves come out from the spinal cord, the disc herniation should affect things in a reverse order from what I just told you: muscle, sensory, and then pain. Nonetheless, this happens. Some people think that the inner core from the disc that herniates is really caustic, and it causes a chemical irritation of the nerves. But again, nobody really knows.

In most cases, luckily, this little bit of cord that pokes out of the disc gets reabsorbed by the body. In orthopedic literature, the estimate is about 75 percent of the time. Also, initially after injury, you would expect and can often see a lot of localized soft tissue swelling in that same area, making a definitive diagnosis difficult even with an MRI. That's why the recommendation is often to wait at least four weeks before getting an MRI and treat someone just on a clinical basis. If you truly have a nerve problem, you will end up with a positive EMG/NCS that should be done on both arms and must include the muscles that run up and down the spine. Otherwise, you can't make a diagnosis of cervical nerve root problem.

In terms of treatment, it is important to get people mobilized as soon as possible. Keep them out of bed after the first two or three days have passed, because the discs themselves act as shock absorbers between the vertebrae.

In this case, the cervical vertebra really don't have their own blood supply. The only way they're going to get healthy again is by sucking the nutrients out of the surrounding vessels. The only way they can do that is with normal axial motion, which does not happen when someone is lying in bed. That's number one. Number two, when people lie in bed, they become de-conditioned, and they also start to lose the calcium out of their bones. So, you do no one a favor by allowing them to stay in bed too long, especially after a disc herniation. Dermatones are just maps of where, if you took a pin or a pinch or a sharp/dull test or a two point discrimination sensory test, you would see changes secondary to the nerve root being compressed or irritated by the disc herniation.

Finally, people sometimes develop complaints of pain related to compression of a nerve within a bony canal or within a ligamentous canal. The most common of these, of course, is carpal tunnel syndrome, where the median nerve may be compressed within the carpal tunnel at the wrist. Most of the literature suggests that carpal tunnel syndrome is primarily an injury to the nerve that is aggravated perhaps by repetitive flexion/extension work activities; bicycle riding, especially down on the drops; vibratory hand tools; or the "old scrubber woman" injury. The nerve compression injuries are really characterized by numbness or tingling in the distribution of the nerve more than pain. Pain is actually not the predominate complaint for most of these people. One exception to that is a peripheral neuropathy related to diabetes, but that should actually affect all four limbs, maybe the hands more than the feet or the feet more than the hands in any given individual. The complaints are distal to, meaning "away from," the body in relation to the point of compression. So, with carpal tunnel syndrome, the carpal tunnel is here and the complaints are going to be in the fingers.

You can localize this by tenderness and tapping over the nerve. Tapping should produce a characteristic shooting in the distribution of the nerve called the Tinnel's sign. The NCS test should be abnormal. Be aware that low temperature or swelling can adulterate the results though. When you evaluate those tests, look to see that the person doing the test measured the temperature of the skin and made a notation about swelling or skin integrity. In your handout, you have a sample IME that I did. I changed the names and the places to protect the innocent and the guilty. I chose that particular one because there were some features of that examination that led me to believe that the puzzle pieces weren't all fitting together nicely. That particular person had a pretty bad crush injury to the foot, with some fractures. In that particular case, I had the records before the exam, and I was doing the exam to rule in or rule out the diagnosis of RSD. In the records, there was notation of swelling and discoloration that went on for a couple of months after the injury. When I examined this person, I was kind of expecting to maybe see some long-term objective findings consistent with RSD. I did see evidence that he had had the fractures, that he had had surgery and treatment, but I also found some other things.

He came to the examination with a cane, and I asked him if he needed to use that cane all the time, and he said yes. I said why, and he said that when he walks around, his foot gets weak and he stumbles and falls, so he keeps it with him and he uses it." Indeed, I had him walk around during the exam and he didn't use his cane but he was kind of hugging the wall and leaning against the wall, as if to show me that he was weak in that leg. Unfortunately, after that examination, I stood and I watched him as he exited. He went through the doors of the reception area, where I had done the exam, and even though the door and the wall were glass, he picked his cane up, stopped limping, and walked into the elevator, which I thought was interesting because I would have thought he would have known they were glass.

The other thing about that exam that I thought was really interesting was that his attorney was there, and his attorney was very interested in making sure that he told me the right story. For example, he showed me his shoes, and I looked at his shoes and he had Rockports. I said that he has Rockports, and he said that it's the only kind of shoe he can wear. I said that I see he has inserts in both shoes. I'm thinking, why would you have inserts in both shoes? That doesn't tell me that you have RSD. He said that he always wears those inserts, and his attorney said, "Always – that's very dangerous. You mean always since your accident, don't you." Of course, he agreed with his attorney.

If an attorney sends me records that are nicely put together in a binder with a chronology and dividers, the first thing that I do, is I take it all apart. I reassemble it, and I look to see what is missing. I do that because I like to put records together chronologically. I like to look at every record I get; I like to see every record. I want to see those irrelevant records from the past, because I want to see what other doctors' names are there that I didn't get. This is important whether I do an exam on behalf of the defense or plaintiff because I can't answer any questions to a reasonable degree of medical certainty without knowing that I have as complete a picture as possible. In workers'

compensation, I never get complete records, and I'm left having to answer on objective findings, verbal history, and what little I have and piecing the puzzle together that way.

In terms of bigger cases that go before a jury, it is very embarrassing to me to have somebody say, "Well, you didn't see this." There really is no reason that I shouldn't get all the records. There is more of a problem here. If I put in my report that I want these particular records and I don't get them, then that's even worse because the logical question is: "Well you asked for these records, why didn't you get them?" So, I like to look at the records. It is amazing to me how many times I have talked to these people who say they can't do anything, who insist that they're indoors, and who have records about needing treatment for poison ivy. I don't know how they got the poison ivy when they were staying inside all the time. That's a record that someone might think is irrelevant, but to me it's very important.

An attorney can say to me on the stand, "Well, you thought they were suntanned, but how do you know that isn't their natural color?" This does several things to me. One, it implies that maybe I have prejudice about color, which is a bad thing in front of a jury, and two, it suggests that something was wrong with my vision that day, because I guarantee you that by the time we come to court the person doesn't have a suntan anymore. When I have in my hand a record that says I know that I saw that suntan or that there was poison ivy, then I would feel better too.
The other thing that is important about records has to do with the verbal history. Recently, I was examining someone who happened to be a physician. Because he was a physician and a likeable guy, I really wanted to believe him, but he had his paralegal with him. I was asking him about his pain, and as I did this, the paralegal interrupted and said you'll ask no more questions about the pain. I said that the exam is about pain. How can I find out if I don't ask the questions? The paralegal said, "If you keep asking these questions, we'll just leave." I'm thinking disaster; they'll never come back. So I collected myself, continued the exam, and stayed away from any questions about the pain. But number one, this was excessive advocacy, because in my mind I couldn't think why this was happening; and number two, when I went to the records, which were nice and complete, I found out that there had been multiple other accidents that weren't reported by this person. In addition, there had been a huge hiatus in treatment for the accident in question and onset of current complaints that he had. Then I understood why there had been the advocacy, but it wasn't helpful to that poor physician whom I wanted to believe.

Is the physical examination consistent and do all of the pieces of the puzzle fit together? The person who brings the cane in and says to me, "I always use this cane," should have evidence that they always use the cane. Leaning on a cane throws your weight forward, so if your right foot hurts, you should be using it in your left, and your litisumus muscles and the muscles along the side of your chest on the left should be bigger than on the right. Not only that, but if you're really not weight bearing on that right leg, than the muscles down here along the spine, should be smaller. If that's not the case, than the pieces are not fitting together.
And with that, I'll end.

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Management of Chronic Pain: What Employees and Employers Need to Know about Treatment with Opioids

Jasen Walker, Ed.D., CRC, CCM, and Fred Heffner, Ed.D.

Background: The Problem

An iatrogenic disability is one that originates with, or is induced by, medical treatment. For example, opioid dependence or addiction (the National Institute on Drug Abuse defines addiction as a "chronic, relapsing brain disease") can be induced by physician prescription when the medications prescribed are not properly used and monitored. Opioids, or "painkillers," are synthetic narcotics with chemical properties similar to opium prescribed to relieve pain and include morphine (for severe pain) and codeine (for milder pain). OxyContin, Percocet, and Vicodin are common brand names of opioid medications, and when taken exactly as prescribed, they can effectively treat pain symptoms. However, these medications are frequently abused, causing dependence and an increasing number of deaths due to overdose. In fact, the Centers for Disease Control and Prevention (CDC) describe the prevalence of overdoses on prescription painkillers as a "public health epidemic" in the United States. The CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) report some alarming statistics:

- In 2010, 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.
- The highest rates of nonmedical use are among young adults (ages 18 to 25).
- Nearly 15,000 people die every year due to overdosing on prescription painkillers.
- Between 1999 and 2010, painkiller prescriptions increased by 300%.

The New England Journal of Medicine (NEJM) also reports on the prescription opioid abuse epidemic, noting that 60 percent of abused opioids are obtained directly through a physician's prescription and that in many instances, "doctors are fully aware that their patients are abusing these medications or diverting them to others for nonmedical use, but prescribe them anyway." If they are indeed aware of the often-disastrous effects of painkillers, why are doctors still prescribing them?

Recent trends in our attitudes towards suffering and pain, as well as financial incentives or disincentives, are largely contributing to the continuing prescription patterns. Throughout the 19th century, doctors viewed pain as a good thing – it was "a sign of physical vitality and important to the healing process," according to Anna Lembke, M.D., writing for the NEJM. Over the past 100 years, however, there has been a paradigm shift: "Today, treating pain is every doctor's mandated responsibility." Dr. Lembke sites specific legislation and notes, "In contemporary medical culture, self-reports of pain are above question, and the treatment of pain is held up as the holy grail of compassionate medical care."

Unfortunately, prescribing opioid medications for treatment of chronic pain is quicker and cheaper than implementing multidisciplinary approaches to pain management. Additionally, in a society that recognizes a patient's fundamental right to pain control, physicians may be further discouraged from refusing to prescribe opioids in favor of nonmedical treatment options. Disincentives for nonmedical treatment can include fear of litigation for failing to treat/under-treating pain and loss of patients and hospital privileges, according to the American College of Preventive Medicine. Healthcare organizations along with the Drug Enforcement Administration have advised healthcare professionals of the "critical balancing act" of managing pain effectively and aggressively while preventing the misuse and abuse of prescription medications.

The medical community, however, seems to be recognizing that opioid medication is not the cure-all for treatment of chronic pain. In June 2011, the Institute of Medicine (IOM) issued a report on the cost of chronic pain, "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research." The IOM listed several underlying principles that informed its approach to the report, including:

- the committee recognized the serious problem of diversion (the intentional removal of a medication from legitimate and dispensing channels), abuse of opioid drugs, and questions about their long-term usefulness;

- pain results from a combination of biologic, psychological, and social factors and often requires comprehensive approaches to prevention and management; and
- chronic pain has such severe impacts on all aspects of a person's life that every effort should be made to achieve both primary prevention and secondary prevention through early intervention.

The IOM aptly notes that chronic pain severely affects all aspects of a person's life, and that certainly includes a person's work. Organizations such as SAMHSA and the National Business Group on Health are addressing the significant effects of substance abuse, and more specifically prescription drug abuse, on the health and safety of workplaces, as well as its significant costs for employers in expenditures for health care, workplace injuries, disability payments, and productivity losses.

Opioids' Shortcomings in the Treatment of Chronic Pain

The goal of opioid therapy is to reduce pain perception to the brain, and thus alleviate the patient's pain and improve his or her function. Because chronic pain is indeed persistent, rather than acute or short term, a person with chronic pain seeks relief over a longer period. However, because organisms build a tolerance to the effects of narcotics, the effective dose must increase over time.

Moreover, the analgesic effect of each dose is time-limited to approximately three to four hours. Consequently, one is left to take more and more of the chemical to experience the desired therapeutic effect throughout the day as the body and mind gradually learn to need increasing amounts of the chemical for both pain relief and homeostasis. Meanwhile, the individual with chronic pain becomes dependent on the temporary relief of the opioid compound and its side effects, which include hormonal changes causing depression and reduced energy; hyperalgesia, or increased pain sensitivity; sedation and drowsiness; and sleep disturbances. These stuporous effects engender passivity and reduce the pain patient's ability to take an active part in managing his or her chronic pain. In other words, treating chronic pain primarily or exclusively with morphine and/or similar compounds postpones, or even eliminates, the necessary effort individuals must carry out to cope with chronic pain.

In her book, "Managing Pain Before it Manages You," Dr. Margaret Caudill, an internist and instructor of anesthesiology at the Dartmouth Medical School, encourages chronic pain patients to accept ownership of their pain and learn coping skills to recapture their lives. However, Dr. Caudill recognizes that this self-ownership can be a challenge for pain patients, as a significant contribution to the reinforcement of chronic pain is "learned helplessness." What we have described elsewhere as injured worker helplessness is the loss of motivation and subsequent inactivity due to an individual's perceived uncontrollability, often post-injury, and in the context of personal injury litigation, workers' compensation claims, and even within one's family. Moreover, it is easy to imagine how the physiological and psychological side effects of opioid use, as well as the effects of opioid dependence, addiction, and withdrawal, can compound the loss of control and acquiring of helplessness in the chronic pain patient. In fact, the CRCC, the CDMSC, and the CCMC define autonomy (to respect the rights of clients to be self-governing and support independent decision making) as one of their principles within their individual *Code*; the effects of opioid arguably detract from the pain patient's autonomy for self-governance.

Dr. Caudill and numerous other healthcare providers and organizations recognize that opioid treatment in chronic pain will not free the patient from chronic pain. Additionally, proper management of chronic pain in primary care settings and the effectiveness of long-term opioid therapy remain controversial and largely understudied. However, one study to determine the efficacy of long-term opioid therapy for improving pain and function with minimal side effects or risk found that in "typical" chronic pain patients, psychological factors are significant and opioids appeared to do more harm than good. Long-term opioid therapy use was found to be appropriate for only a very small, carefully selected group of patients.

The American Pain Society and the American Academy of Pain Medicine commissioned a systematic review on opioid therapy and noted a similar finding: chronic opioid therapy *can* be an effective choice for *carefully selected and monitored* patients with chronic noncancer pain. However, the *Journal of Pain* reports in its "Opioid Treatment Guidelines," that "opioids are also associated with potentially serious harms, including opioid-related adverse effects and outcomes related to the abuse potential of opioids." The Guidelines recommend that patient selection and "risk stratification" include a comprehensive benefit-to-harm evaluation that weighs the potential positive effects of opioids on pain and function against potential risks, or the likelihood for drug abuse, misuse, and addiction. In

addition to determining the underlying biological source of pain, the risk stratification evaluation must also include a thorough assessment of psychosocial factors and family history.

As noted above, *pain results from a combination of biological, psychosocial, and social factors*, and often requires comprehensive approaches to prevention and management. Treatment options for pain include pharmacological and/or nonpharmacological modalities, and problems frequently arise when those managing patients' chronic pain opt for the former instead of or without the latter.

Treating Pain: The Biopsychosocial Model

Pain management methodologies among physicians and treatment specialists are shifting from a "biological model" of pain to one focused on the psychological and social aspects of chronic pain. Because pain often produces and is accompanied by psychological and cognitive effects such as anxiety, depression, and anger, according to the IOM's recent report, interdisciplinary, biopsychosocial modalities are the most promising for those with chronic pain. Nonpharmacological treatment options focusing on psychological aspects of pain include counseling, facilitation of self-care, cognitive-behavioral therapy, relaxation training, and psychotherapy for comorbid conditions.

The American Psychological Association (APA) is also advocating for integrated care in the treatment of pain, frequently referred to as a "mind-body" approach. As an example, the APA reported on psychologist Mark B. Weisberg's three-tiered intervention with pain patients:

- In the first tier, he teaches patients cognitive techniques to help prevent pain;
- then he focuses on specific stressors at work or home that exacerbate pain symptoms;
- and finally, for those with the most complex and chronic pain symptoms, he uses strategies such as hypnosis and focused psychotherapy to identify and attack emotions that may be setting off autonomic nervous system responses that aggravate physical symptoms.

Ultimately, it is important to remember that pain, including chronic pain, is a subjective experience, as each person perceives pain and its severity in a unique way. Understanding this, it is clear that indiscriminately prescribing opioids for individuals with chronic pain is not always an effective means for treatment, and in fact, studies have shown that opioid therapy may indeed be counterproductive, causing more harm than relief for certain patients. In short, the biopsychosocial (or integrated care) approach, which emphasizes the psychological and social aspects of pain, is integral to thorough chronic pain treatment.

How the Abuse of Prescription Drugs Manifests Itself in the Workplace

Opioid use has potentially devastating implications for chronic pain patients' functionality and return-to-work prospects. A 2009 study, published in *The Journal of Bone and Joint Surgery*, tracked patients who suffered a chronic, disabling occupational musculoskeletal disorder and were subsequently admitted into an interdisciplinary functional restoration program. Some participants reported opioid use at the time of admission and some reported no opioid use. The authors concluded, "Chronic opioid use beginning after a work-related injury is a predictor of less successful outcomes for patients whose final treatment intervention is an interdisciplinary restoration program." Results indicated that a higher post-injury opioid dose was associated with a greater risk of program non-completion.

The authors also reported on socioeconomic outcomes, noting a relation between high opioid use and lower rates of return to work and work retention, as well as higher healthcare utilization. Furthermore, one year after the observed treatment, the group reporting the highest opioid use was 11.6 times as likely to be receiving Social Security Disability Income/Supplemental Security Income as compared with the group reporting no opioid use at the time of admission. A 2008 study on patients with chronic disabling occupational spinal disorders at the initiation of functional rehabilitation came to similar conclusions, i.e., prescription opioid dependence may be a risk factor for less successful long-term work and health outcomes.

Opioid use and abuse affects not only pain patients' functionality and motivation to return-to-work, but also has significant costs within the insurance and healthcare system, which ultimately increases costs for employers. According to a 2012 article in the *New York Times*, insurance payments (including workers' compensation) for

major workplace accidents are being overtaken by the costs of routine workplace injuries that are treated with strong opioids. The article states that workplace insurers are now spending an estimated $1.4 billion annually for opioids, or narcotic painkillers, to which an individual can quickly become addicted, thus prolonging the time he or she takes to return to work. Generally, as indicated by the above-mentioned studies, when individuals are on opioids for long periods of time, they often do not return to work.

The article also states that while the cost of a typical workplace injury is approximately $13,000, that cost rises dramatically when painkillers are prescribed. Further, the strength of the prescribed painkiller is a factor:

- the average cost of a worker prescribed a short-acting drug like Percocet is $39,000, triple the cost of a typical workplace injury, and
- the cost of a stronger, longer-acting drug like OxyContin is tripled again to $117,000.

The irony of the high cost for painkillers is that they became popular as insurers worked to cut back, or even phase out, physical (and mental) therapies as the usual treatment for non-major injuries. The result is higher costs in healthcare coverage for employers and employees.

Opioid use and abuse has many potentially disastrous implications for the workplace in the form of expenditures for health care, workplace injury, disability payments, productivity losses, and lost time. Thus, it is important for employers and human resources professionals to be familiar with the signs of and problems that arise from employee opioid abuse and addiction. The National Business Group on Health, in An Employer's Guide to Workplace Substance Abuse, references results from a survey of human resources professionals. According to the survey, the most significant problems companies experience due to employee substance abuse, including prescription drugs, are absenteeism, reduced productivity, lack of trustworthiness, negative impact on the company's external reputation, missed deadlines, increased healthcare costs, and unpredictable defensive interpersonal relations.

In addition to the extra monetary cost for employers, as well as health and safety problems, it is seen in the human resources survey that the psychosocial issues that underlie and arise from opioid abuse, for example, can just as drastically affect work environments. Additionally, as mentioned above, workers who report opioid use after a workplace injury are less likely to succeed in their rehabilitation attempts. Opioid dependence can also engender injured worker helplessness, or the perceived loss of control in an injured worker and subsequent lack of motivation to return to work. These issues compound to create a significant and costly problem for employers and employees alike.

What Employers Can Do

The CDC stated in 2012: "Prescription drug abuse is the fastest-growing drug problem in the United States." In response, some states have legislated, or are considering legislation, to address the problem. Some ways employers are working with their legislators to support meaningful action on issues that impact the workplace include:

- The Internet System for Tracking Over-Prescribing (I-STOP) bill (New York)
- Setting up a state operated prescription monitoring database (New York)
- "Doctor shopping" for prescriptions recognized as a crime punishable by a year in jail (Alabama)
- Oversight powers on pain-management clinics (Indiana)
- Licensing of pain clinics (Kentucky)
- Setting dosage limits for doctors prescribing pain medications (Washington state)

Since many, if not most, abusers are employed, this kind of advocacy can return significant rewards for employers who urge the passage of such state laws.

For workplaces, safety programs that educate workers on the risks of prescription medication abuse and policies the company has developed to address the abuse of these drugs should be part of the organization's culture.

SAMHSA provides programs specifically for employers in terms of prescription drug misuse, including its webinar on the prevention of prescription medication abuse in the workplace.

Alternate methods employers and their disability management programs could use as remedial approaches when substance abuse of opioids is identified include physical therapy, behavior modification, acupuncture, yoga, exercise, and/or weight loss. Dr. Caudill recommends life-style modifications, including mind-body techniques, increasing one's activity, developing and maintaining good nutrition, finding help for insomnia and sleep disorders, and reducing the use of alcohol.

These specific methods are aspects of the Employee Assistance Program (EAP) already operating in many companies. EAPs will serve an increasingly important role, especially when substance abuse seems to be associated with absenteeism, presenteeism, and other workplace dysfunctions. EAPs have been a substantial asset to employers and employees who struggle with both the occupational consequences of illicit and prescribed drug abuse and chemical dependency. When there is no EAP, the company may find specific resources readily available at contract events in the local community.

Articles Available from CEC Associates, Inc., on Pain and Disability:

CEC Associates, Inc., has sought, over the years, to identify resources for employers on the issue of chronic pain. We recognize that pain has long been a primary concern for employers as they have tried to address issues of absenteeism and productivity. For more on pain in the workplace, see the following CEC articles:

Pain as a Disability / Issues in Pain as a Disability
A Pain in the Back / Back Problems: Specific Issues / "Well-Managed" Companies & Return-to-Work Programs (three parts)
Strategies for the Use of IMEs: Assessing Pain in the IME
Explaining Acquired Disability & The Workplace Approach to Managing It
Workipedia - Chronic Pain
Injured Worker Helplessness: Critical Relationships and Systems Level Approach for Intervention

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