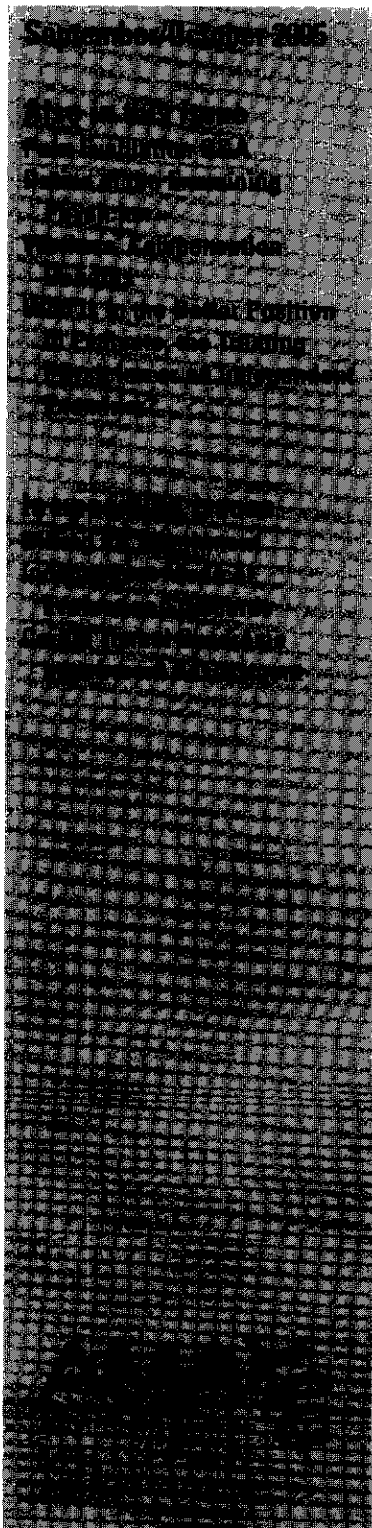


# The Guides Newsletter

Expert advice, practical information, and current trends on impairment evaluation



## Acromioclavicular Joint Arthritis

by Charles N. Brooks, MD, and Christopher R. Brigham, MD

Arthritis of the acromioclavicular joint (ACJ) is a common cause of shoulder pain, either directly or indirectly. The arthritis may be posttraumatic, rheumatoid, septic, gouty, or due to pseudogout, but usually is degenerative.<sup>1</sup>

### Acromioclavicular Joint Degeneration

The cause of degenerative or osteoarthritis of the ACJ, like other joints, is not known with certainty. The fibrocartilaginous intraarticular disc that normally accommodates any incongruity between the convex distal clavicle and concave acromion may be incomplete or absent, resulting in premature degeneration of the articulation.<sup>2</sup> The disc also degenerates with aging, and this begins early, in the second decade. By early adulthood there often is little more than a fibrocartilaginous remnant of the disc.<sup>3,4</sup> Age-related degeneration of the ACJ accompanies that of the disc and is almost universal after the fifth decade.<sup>5</sup>

### Impingement

As implied, ACJ arthritis may itself be a pain generator. However, symptoms more often result from an indirect effect of the arthritis, impingement on soft tissues immediately inferior to the distal clavicle, ACJ, and acromion, the subacromial bursa and rotator cuff tendons, primarily the supraspinatus.

Marginal osteophytosis is one of the four primary radiographic manifestations of osteoarthritis. By 60° of glenohumeral abduction, the rotator cuff contacts the inferior ACJ.<sup>6</sup> Hence, any spur projecting inferiorly from one or both bones on either side of the joint, the distal clavicle or medial acromion, will impinge on and abrade the underlying bursa and tendon during elevation.<sup>7</sup> Other potential sources of impingement include a curved, hooked, or laterally downsloping acromion, and/or the coracoacromial ligament.<sup>8</sup> Either way, by 70° of abduction the humerus is under the ACJ, and the intervening soft tissues can be pinched between any bony prominence above and the greater tuberosity below.<sup>9</sup> The impingement, which begins at about 70° of shoulder abduction or flexion, continues until about 120° of elevation. Impingement syndrome usually involves pain upon and limitation of shoulder elevation, and most commonly occurs in persons whose work or avocational pursuits involve repetitive abduction or flexion (eg, a drywaller, welder, painter, swimmer, or tennis player). It also occurs in those who consistently sleep with the shoulder in significant abduction (with a forearm under the pillow).

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## Rotator Cuff Tears

ACJ osteoarthritis frequently contributes to rotator cuff tears. Rotator cuff tendonopathy generally is multifactorial, and tears usually result from a combination of intrinsic (intratendinous) or extrinsic (extratendinous) factors.<sup>10,11</sup> Intrinsic factors include the significant loads transmitted through the cuff tendons, the limited blood supply at insertion of the supraspinatus tendon, and age-related degeneration. The primary extrinsic factor is impingement. Inflammation of the subacromial bursa and rotator cuff tendon resulting from repetitive compression causes swelling and, occasionally, fibrosis. Hence, the thickened bursa and tendon are even more predisposed to impingement.

One often-quoted autopsy study found that one-third of individuals had full-thickness rotator cuff tears, and 73% of those had a hooked acromion.<sup>12</sup> However, there is an even higher association between cuff tears and inferiorly projecting osteophytes from the ACJ.<sup>13</sup> Like a rope that becomes frayed and eventually breaks when it, for instance, is repetitively slid back and forth across the sharp edge of a rock, repetitive elevation of the shoulder results in abrasion of supraspinatus tendon on these spurs, with attrition that progresses from partial- to full-thickness tears.

## Treatment of Impingement and Rotator Cuff Tears

When nonoperative treatment for impingement fails, or a symptomatic rotator cuff tear occurs, surgery often is warranted. The repair of any cuff tear (when possible) generally involves one or more procedures to eliminate impingement, collectively termed *subacromial decompression*. The decompression often includes acromioplasty, excision of a wedge of bone from the anterior-inferior acromion, thereby removing any downward-projecting curve or hook. Coracoacromial ligament and/or subacromial bursa also may be excised. Given an arthritic ACJ, a surgeon might remove any inferiorly projecting spur from medial acromion or lateral clavicle (cheilectomy), or excise the distal 1-1.5 cm of clavicle (resection arthroplasty). The rationale behind the latter, and more aggressive, procedure is that it not only eliminates impingement from the spur, but it also eliminates another potential pain generator, the ACJ.

Distal clavicle resection (DCR) may be indicated in other clinical scenarios when nonoperative treatment has failed, eg, posttraumatic superior subluxation of distal clavicle (type II ACJ separation) or distal clavicular osteolysis.

## Rating Impairment From Procedures for ACJ Arthritis

The *Guides* provides no impairment rating for cheilectomy about acromioclavicular or other joints, presumably because even though this results in "loss" of a small portion of the body, the bone excised is an abnormality. Excision of an inferiorly projecting spur from distal clavicle should improve function. Because removal of this liability is beneficial, it results in no (and perhaps even negative) impairment. This reasoning is consistent with a prior article in *The Guides Newsletter* stating that uncomplicated acromioplasty results in no impairment.<sup>14</sup>

Distal clavicle excision is listed in the *Guides*, along with other types of resection arthroplasty, in Table 16-27, Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints (5th ed, 506). The table indicates this procedure results in 10% upper extremity impairment (UEI). This rating then is combined with any other shoulder impairment, eg, weakness or loss of motion.

Rating excision of the entire distal clavicle is straightforward. There are obvious, objective physical and radiographic findings. The *Guides* contains a clearly specified means to rate the loss of this portion of the body. Unlike some conditions or surgical procedures for which the rating physician must select from within a range of percentages (which requires judgment and may generate controversy), there is a single rating for this procedure.

A report of 10% UEI due to distal clavicle resection may be controversial for other reasons. First, does removal of 1-1.5 cm of bone from the lateral end of

the clavicle truly result in 10% impairment of the upper extremity? Some would argue that despite the loss of a small portion of normal bone, if done for appropriate indications upper extremity function should be improved postoperatively, and like a cheilectomy result in no or even negative impairment. The *Guides* contains other examples in which loss of a body part, or a portion thereof, does not result in impairment. There is, for instance, no permanent impairment due to splenectomy (5th ed, 199) and no rating for an appendectomy.

Others might point out the importance of the clavicle as a strut in maintaining an appropriate distance between sternum and acromion, and separation of the shoulder girdle from chest wall. Hence, perhaps the 10% rating, or at least some impairment, is warranted for DCR. Unfortunately, current scientific literature does not provide sufficient evidence to corroborate or refute the consensus-based rating for resection arthroplasty of distal clavicle listed in the *Guides*.

A second potential controversy surrounding the 10% UEI for distal clavicle resection concerns not the percentage but causation. Did a compensable injury result in need for this procedure, or was it done for preexisting pathology neither exacerbated (temporarily worsened) nor aggravated (permanently worsened) by the trauma?<sup>15</sup>

Causation analysis may involve consideration of three types of causes in an etiologic sequence: predisposing, precipitating, and proximate. The proximate, also known as the primary, immediate, or inciting, cause, is the trigger that initiates an injury or disease.<sup>16</sup> A precipitating cause permits the proximate cause to act. A predisposing cause permits the precipitating and then the proximate causes to act.

A carpenter who falls at work and lands on the superior right shoulder, sustaining a subluxation (type II separation) of ACJ and undergoing DCR for persistent pain, clearly had an occupationally related procedure. Proximate cause for the procedure was pain due to abnormal alignment of the ACJ. The precipitating cause, which resulted in the ACJ subluxation, was the fall on superior shoulder. Predisposing causes for the fall may have been his foot slipping off the rung of a ladder, or even further removed, the rain that caused it to be slippery. Regardless, the occupational injury resulted in a need for treatment that left the worker with 10% UEI. There is a cause-and-effect relationship between the compensable trauma and impairment.

On the other hand, as implied, DCR usually is performed for reasons unrelated to injury, such as to remove one or more spurs large enough to impinge on adjacent soft tissues or to eliminate a painful, arthritic joint.

An individual who has a job involving repetitive shoulder elevation and develops impingement probably has a legitimate workers' compensation claim, even if he or she is predisposed by preexisting bony prominences at anterior inferior acromion and/or distal inferior clavicle. The initial subacromial bursitis and rotator cuff tendonitis, and later attenuation of the rotator cuff from the abrasion, likely are in part an occupational disease, with some contribution from avocational activities as well. In this scenario the proximate cause was repetitive shoulder elevation. The precipitating cause was whatever patholo-

gy led to impingement with elevation, eg, a spur projecting inferiorly from distal clavicle. The predisposing cause might be a genetic predisposition to osteoarthritis.

While effects of the proximate cause (repetitive work at or above shoulder level) probably are compensable in most jurisdictions, the question arises whether the predisposing cause and treatment rendered are. For example, assume a contractor hires a 55-year-old painter who has osteoarthritis of ACJ. While painting a home the following week, the employee develops recurrent impingement that causes a partial-thickness rotator cuff tear to progress to a full-thickness tear. The resultant pain and weakness disable the painter. Nonoperative treatment fails, prompting arthroscopy, acromioplasty, DCR, and repair of the cuff tear. Is the 10% UEI from the distal clavicle resection causally related to the painter's occupational activities and compensable under the workers' compensation claim?

The rotator cuff tear, although preexisting the painter's relatively brief employment, thereby was worsened. Treatment for the cuff tear presumably will be covered under the claim. Any resulting impairment, such as loss of shoulder motion or weakness, probably is also, at least in part, occupationally related. However, the DCR was performed for a preexisting condition that was not caused and probably not worsened, at least permanently, by painting the house. This portion of the overall surgery was to eliminate a longstanding precipitating cause. There is not a medical cause and effect relationship between the work activities and distal clavicle resection. The painter has 10% UEI due to the procedure, but the impairment is not attributable to occupational activities.

In legal terms, the answer to the question posed above may differ depending on the jurisdiction. Assuming all the shoulder procedures were performed concurrently, and the surgery was covered under the workers' compensation claim, it may be that any impairment from the operation, even if one portion was done for a nonoccupational condition, becomes occupationally related.

## Summary

Acromioclavicular joint arthritis is a common source of shoulder pain. Manifestations of the arthritis may include inferiorly projecting spurs that predispose someone to impingement and rotator cuff tears, and can result in permanent impairment due to shoulder weakness or motion loss. This impairment may be due, at least in part, to occupational activities or injury. However, surgery for ACJ osteoarthritis either results in no impairment (cheilectomy) or impairment that is not occupationally related (distal clavicle resection).

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*Continued on page 12*

## Pain-Related Impairment Questions

by Christopher R. Brigham, MD

Pain is a challenging problem for everyone, including the rating physician. The following questions are some of the many asked about rating pain.

### Question

**Should most permanent impairment ratings also include a rating for pain?**

### Answer

No. Chapter 18 is rarely applicable. I would estimate far less than 1% of the ratings I review on a national basis (excluding California) incorporate further impairment for pain, even though pain is the most common complaint in impairment evaluation. (California recently adopted the use of the *AMA Guides*. Physicians there are accustomed to a system that bases ratings on subjective reports, and these physicians generally are inexperienced in the use of the *Guides*.) Section 2.5e, Pain, advises that “the impairment ratings in the body organ system chapters make allowance for any accompanying pain” (5th ed, 20). Therefore, the rating of pain is limited to specific circumstances as discussed in Section 18.3a, When This Chapter Should Be Used to Evaluate Pain-Related Impairments. The inherent subjectivity of pain makes it much more difficult to consistently rate under the *Guides*, where the standard methodology for rating impairment is based on objective measures of organ dysfunction. Many experienced examiners therefore restrict rating of pain to extraordinary circumstances involving a well-recognized medical disorder and severe pain that has persisted for a minimum of 6 months. Examples of such relatively uncommon scenarios include amputations with phantom pain, headaches secondary to significant head trauma, and postparalytic pain.

### Question

**In the case where pain is rated, must a physician perform a formal pain-related impairment (PRI) assessment?**

### Answer

No, not necessarily. If the physician’s judgment is that pain should be rated and an examinee’s burden of illness exceeds the conventional impairment rating (CIR), it may be appropriate to award PRI. The crucial issue here is whether the physician decides on the basis of the informal assessment that pain increases the burden of illness of the examinee *slightly* or *substantially* beyond the CIR he or she warrants. The physician should perform a formal PRI assessment only if he or she believes that pain

*substantially* increases the burden of the illness. In either case, the quantitative rating is no more than 3% whole person permanent impairment. A formal PRI assessment places an individual into 1 of 4 qualitative classes: mild, moderate, moderately severe, and severe.

### Question

**Is it appropriate to select a higher or the highest rating for spinal impairment in a DRE category and combine this with impairment for pain from Chapter 18?**

### Answer

No. It is inappropriate to rate spinal impairment using the diagnosis-related estimates (DRE) method, select 1 of the higher or the highest rating for a category based on limitations in activities of daily living (ADLs), and then award up to an additional 3% whole person impairment (WPI). The limitation in ADLs presumably is due, at least partially, to residual pain. Awarding further impairment for pain from Chapter 18 therefore is duplicative by rating the same impairment twice. This problem of “double dipping” was examined in the March-April 2005 issue of *The Guides Newsletter*.

### Question

**What are some examples of ambiguous or controversial pain syndromes that are not ratable by the *Guides*?**

### Answer

Chronic fatigue syndrome, myofascial pain syndrome, myositis and fasciitis without objective findings, fibromyalgia, sick building syndrome, multiple chemical sensitivity (idiopathic environmental intolerance), neurogenic thoracic outlet syndrome, spinal subluxations not visible on MRI or CT scan, and other functional somatic syndromes are based on symptoms, eg, widespread pain, and/or subjective or unverifiable physical findings such as tenderness. Despite extensive research, no specific underlying biological abnormality has been discovered to explain the reports of these people. Since the medical community has not achieved a consensus on how to construe such conditions, they are not to be rated as having permanent impairment.

### Question

**A patient with chronic pain reports difficulty with sleep. Can the patient be rated using Table 13-4, Criteria for Rating Impairment Due to Sleep and Arousal Disorders?**

## Answer

No. Chapter 13, The Central and Peripheral Nervous System, provides "criteria for evaluating permanent impairments due to documented dysfunction of the brain, cranial nerves, spinal cord, nerve roots, and/or peripheral nerves and muscles" (5th ed, 305). Neither pain nor reports of sleep disturbance represent an objective documented dysfunction of the brain.

## Question

**If an individual undergoes an impairment rating of all 3 areas of the spine (cervical, thoracic, and lumbar) according to the DRE method in Chapter 15, and falls into Category II for each, could he or she conceivably obtain the highest rating in Category II, 8% whole person permanent impairment (WPI), for all 3 spinal segments, or is the maximum rating (the baseline 5% plus 3% WPI for limitation in ADLs) applicable to only 1 area of the spine?**

## Answer

It is possible to receive a higher or the highest rating in 2 or all 3 spinal DRE categories. Therefore, if someone had findings resulting in a DRE Category II rating for the cervical, thoracic, and lumbar regions, it is possible to have a combined impairment rating as high as 22% WPI (8% combined with 8%, combined with 8%). However, it is unusual to have an injury that results in significant ratable impairment in all 3 regions. If an evaluating physician reports a rating at the maximum for a DRE Category in all 3 regions, it would be appropriate to determine if: 1) the reports of interference in activities of daily living are valid, 2) the findings are reliable, and 3) the examiner is unbiased. Typically, an examinee with a multiple region injury will report greater limitations from 1 area than another. A claim that each of the 3 spinal segments results in marked interference with activities of daily living should raise concern about illness behavior.

## Question

**An individual sustained a cervical injury and was rated as having 8% whole person permanent impairment (WPI) due to limitations in activities of daily living (ADLs) according to DRE Category II. Could this person be awarded up to an additional 3% WPI according to Chapter 18 for accompanying headaches, or is the discretionary 3% WPI provided under the cervical spine the maximum?**

## Answer

It would be very rare that headaches would result in further impairment. If, for example, a motor vehicle accident resulted in significant head and neck injury, it is possible there would be additional impairment for the

headaches. The rating of impairment due to cephalgia typically is restricted to a well-defined headache disorder, causally related to the ratable event. If the headaches were occipital, it is probable they were associated with the cervical spine pathology.

## Question

**If an individual having both elbow and lumbar injuries is rated as having 8% whole person impairment due to the low back trauma per DRE Category II of Chapter 15, but also has difficulty with activities of daily living (ADLs) due to permanent elbow impairment, could he or she be awarded up to an additional 3% WPI according to Chapter 18 for the residual difficulties in the elbow?**

## Answer

It is unlikely that an elbow problem would be a source of a pain syndrome that would qualify for use of Chapter 18 to rate impairment. Chapter 16 incorporates the pain that is present in the ratings. Many conditions, like elbow tendinopathy, are painful but do not rise to the level of an impairment. Section 16.7d, Tendinitis (5th ed, 507), discusses these syndromes.

## Question

**If an individual has an impairment rating for a total hip or knee arthroplasty (Table 17-33, pages 546-547; Table 17-33, page 549; Table 17-34, page 548), and since pain is scored in Tables 17-33 and 17-34, would it not be duplicative to also include an impairment award for pain from Chapter 18?**

## Answer

Yes, it would be duplicative and therefore inappropriate. Since pain is a major determinate in the total hip or knee arthroplasty outcome score, the conventional impairment rating (CIR) already encompasses the impairment for pain.

## Question

**Is the maximum 3% whole person impairment (WPI) allowed according to Chapter 18 an overall 3%, or can an individual conceivably receive the discretionary 1%, 2%, or 3% WPI for difficulties with ADLs due to chronic pain for more than 1 area of the body (eg, elbow, knee, or ankle)?**

## Answer

If it is appropriate to use Chapter 18, the 3% WPI for pain can be assigned either for a single body part or attributed to the impact of impairment from multiple regions. However, in no circumstance may the total impairment provided from Chapter 18 exceed 3% WPI.

# Duties of the Examining Physician

by Alan Colledge, MD

The physician performing an impairment evaluation should base the rating on the objective condition of the patient along with the credible subjective findings. Section 2.3, Examiners' Roles and Responsibilities (5th ed, 18), states "the physician's role in performing an impairment evaluation is to provide an independent, unbiased assessment of the individual's medical condition, including its effect on function, and identify abilities and limitations to performing activities of daily living as listed in Table 1-2. Performing an impairment evaluation requires considerable medical expertise and judgment."

In making interpretations and judgments, the examiner has obligations that are distinct from the duty of care as a treating physician. The impairment rating is not considered a portion of any medical service previously rendered and is not included in routine postoperative care. Unless treating physicians are uncomfortable with this process, they are encouraged to declare the patient stable, and, if applicable and if they are qualified and able to be unbiased, to calculate an impairment rating. The skills involved in assessing impairment are two-fold: clinical assessment and criteria application. An experienced attending clinician may be unfamiliar with the correct process of rating impairment or may not feel comfortable in being unbiased in performing the rating.

If for any reason the attending physician prefers not to make this evaluation, he or she should notify the responsible party adjusting the claim for an insurance carrier or government payer. The treating physician then may refer the patient, or request that the adjuster refer the patient, to a physician with training and expertise in the patient's condition and with knowledge of the impairment rating methodology adopted by the jurisdiction. Alternatively, the attending physician may provide a physician knowledgeable in the use of the *Guides* the necessary data to apply against *Guides* criteria. The rating physician needs to ensure that the examinee understands the evaluation's purpose is medical assessment, not medical treatment. However, if significant new diagnoses are discovered, the physician has a medical obligation to inform the requesting party and individual about the condition, and to recommend or refer for further

medical assessment. It is recommended that the evaluating physician not cross the boundaries and become a treating physician for that patient. This "medical obligation" is important for identifying significant, previously unrecognized medical conditions, such as hypertension or malignancy.

The attending physician often is the person most knowledgeable regarding the condition, progress, and final status of the injured employee. Therefore, the treating physician may be encouraged to render the final impairment rating (page 18). However, the treating physician may find it impossible "to provide an independent, unbiased assessment" (page 18), or may be inexperienced in the complexities of assessing impairment. When the physician or rater is uncertain about which method to use in the calculation of an impairment rating, or if more than one method can accurately be used, the physician or rater should calculate the impairment rating using different alternatives and choose the method or combination of methods that best represents the functional impairment of the examinee (pages 526-527). Depending on the jurisdiction, there may be specific constraints and duties on how the rating is to be done. In such cases, the law trumps physician discretion.

The patient's history should primarily be based on the individual's own statements rather than secondhand information, assuming the individual's statements are reliable. The physician should consider information from all sources, including medical records. However, caution should be used in the interpretation of subjective information, particularly in the context of litigation and the potential for secondary gain. Although it is not appropriate to question the individual's integrity, it is appropriate to comment on the individual's credibility. The credibility of patients' representations should be interpreted in light of their consistency across time and in accordance with objective findings. If information from the individual is inconsistent with what is known about the medical condition, circumstances, or written reports, the physician should comment on the inconsistencies and should base ratings on consistent historical reports and findings (pages 374 and 524).

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## Workers' Compensation Benefits

by Alan Colledge, MD, and Greg Krohm

Workers' compensation systems provide benefits for medical care and disability. The total estimated cost of workers compensation benefits in 2002 was 53.4 billion dollars.<sup>1</sup> Terminology may differ from jurisdiction to jurisdiction, but most of them recognize 4 broad divisions of claims benefits:

- Medical-only
- Temporary disability, for wage loss indemnity (TTD)
- Permanent disability, divided into Permanent Total (PT) and Permanent Partial Disability (PPD)
- Death (including burial)

Most workers' compensation injuries require only medical attention and do not involve lengthy time away from work, nor do they leave residual effects on the worker. In the United States, "medical-only" claims are about 72% of all compensable injuries.<sup>2</sup> These claims do not involve compensation for lost work time, except for medical expenses related to an injury. The percentage of medical-only claims in a jurisdiction is a function of the quality and speed of medical care, the length of lost time required before an injury qualifies for indemnity benefits, and how scrupulously employers report claims as workers' compensation.

Under workers' compensation, when the injured worker has missed a predetermined amount of time from work (1 to 7 days, most often 3 days), he or she is eligible for wage indemnification, with the amount determined by each jurisdiction. Wage loss benefits continue until the disabling condition either permits a return to work or reaches a plateau where healing ends and no significant improvement is likely, which is called *maximum medical improvement* or *permanent and stationary*. When this occurs, the injured worker may be entitled to another class of benefits to compensate for any permanent residual loss, ie, PPD or PT.

Most state, provincial, and national systems make some allowance in the law for payment of cash benefits upon proof of objective or reasonably inferred permanent injury to a worker. A permanent injury is one that causes

damage to an organ or bodily system that reduces its function and is expected to last for life. These permanent injury benefits presumably compensate the worker for likely or inferred loss of income from the bodily injury. This tie-in between income loss and permanent disability benefits is approximate and highly inconsistent from jurisdiction to jurisdiction. It is worth noting that some jurisdictions do not compensate for objective permanent injury to the body, but will for permanent wage loss due to the injury or likely to ensue from the injury.

Fortunately, claims for death benefits are relatively infrequent. In 1999, there were 6023 fatal work injuries out of 5.7 million Occupational Safety and Health Administration (OSHA) reportable injuries (.1%).

As Table 1 shows, about one-fourth of claims in the United States involve permanent injury benefits, yet they produce about two-thirds of the cash benefits paid. Of the \$25.3 billion in cash benefit payments going directly to

injured workers in 1999, nearly \$19 billion were for compensation of permanent injury.

Using the median value for the 12 states that participated in the 2002 Compscope project, 46% of all claims with more than 7 days of lost time had a permanent partial

disability (PPD) benefit. The median PPD benefit was \$10,523 compared to a median benefit for Temporary Disability of only \$2442.

How the award is calculated for these permanent claims differs from jurisdiction to jurisdiction. In some jurisdictions, permanent injury benefits are awarded only on the direct physical loss. Other jurisdictions compensate to some measure for expected wage loss, the loss of employment options, extra expenses from accommodating the disability, or perhaps an implicit award for psychological loss and pain. Some jurisdictions, such as in California, will adjust a permanent impairment rating by a Future Earning Capacity modifier, occupation, and age. Once again, the laws in each jurisdiction differ in philosophy and practice.

Table 1. Workers' Compensation Cases in the United States, 2000<sup>3</sup>

Type of Workers' Compensation Claim	Percentage of Cases	Percentage of Cash Benefits
Temporary	72	25
Permanent Partial	27	62
Permanent Total	1	13

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## Who Is in the Better Position to Evaluate, the Treating Physician or an Independent Examiner?

by Robert J. Barth, PhD, and Christopher R. Brigham, MD

Who should evaluate? The answer to this commonly asked question is, "It depends." It depends on the issues, the context, and the evaluator. A treating physician knowledgeable about the use of the *Guides* may be the appropriate professional to evaluate impairment in certain circumstances. However, in cases dealing with issues such as pain, disability, and medicolegal (forensic) issues, a truly independent medical examiner typically is more appropriate.

Section 2.1, Defining Impairment Evaluations, states that impairment evaluations "may be performed by a treating physician or a nontreating physician, depending upon the state's requirements and the preferences of the individual, physician, and requesting party" (5th ed, 18). The evaluation must be performed by a physician; it cannot be performed by a nonphysician, such as a physical or occupational therapist or an acupuncturist. Depending on jurisdiction language, the term *physician* may refer to an allopathic, osteopathic, or chiropractic physician, a psychologist, or a dentist.

In contrast to the above quote, which indicates that a treating physician can perform an impairment evaluation, the *Guides* also specifies that the evaluator's role must be independent: "The physician's role in performing an impairment evaluation is to provide an *independent, unbiased* assessment of the individual's medical condition, including its effect on function, and identify abilities and limitations to performing activities of daily living as listed in Table 1-2" (5th ed, 18). By definition, the physician is not in an independent role if that physician already has accepted a treating role for the patient/examinee. Subsequently, the *Guides* fails to provide unequivocal direction on this issue.

As was noted above, the physician must be *independent and unbiased*. This can be challenging for any evaluator. For example, an independent evaluator may not be unbiased if he or she strays from the standards of the *Guides* and distorts ratings in a fashion that will be more favorable for clients. However, these issues are more likely to be problematic for the treating physician since there is an inherent patient advocacy role. It is probable that the treating physician will not consider new or alternative diagnoses at the time of rating. It also is possible that the treating physician will causally relate problems to an injury if this appears advantageous to the patient and/or the physician. For example, if a treating physician receives referrals from plaintiff counsel, it is not unexpected that this physician will causally relate problems to the defined injury and possibly inflate a rating. A treating physician caring for a patient in a managed-

care situation may be more likely to relate a problem to an injury if this provides an additional source of revenue. The treatment role may influence when a physician defines the patient at maximal medical improvement (MMI). A treating physician may want to inflate a rating, particularly if the impairment number does not appear to reflect a level of perceived disability. A physician alternatively might want to portray a positive outcome from therapeutic interventions, and thus would underrate findings, particularly those that are difficult to quantify such as neurological findings. Therefore, being totally "independent and unbiased" may be a challenge.

From a practical perspective, many jurisdictions suggest that the treating physician should perform the rating evaluation. This physician already is familiar with the patient, the evaluation often can be performed on the basis of clinical findings when at MMI, and the process typically is more expedient and less costly than arranging for an independent medical evaluation. Causation often has been defined at the time of rating a work-related injury, and there is an adequate basis to rate impairment. A treating physician who is knowledgeable and skilled in the use of the *Guides* often can perform impairment evaluations for common problems such as rating an amputation, a wrist fracture with limitations of motion, a lumbar discectomy with a good result, and a partial meniscectomy. However, a treating physician doing an occasional evaluation is unlikely to develop the adequate knowledge and skills to assess more complex impairment, causation, and other medical-legal issues.

In this article we will focus on some of the inherent conflicts in the roles between treating physician and evaluating physician, whether this is for impairment assessment or other forensic issues.

### Considerations From Chronic Pain Literature

In a 1992 article published in the *Archives of Internal Medicine*, Sullivan and Loeser<sup>1</sup> pointed out that it was unethical for a physician to serve in both a treating and an impairment evaluation role for the same patient when the focus of treatment is chronic pain. They explained there are fundamental differences between the physician-patient relationship and the evaluator-examinee relationship.

Inherent in this discussion is an issue of role confusion. The treating physician's purpose is to reduce suffering, while the evaluator must avoid such considerations in favor of assisting with administrative needs. The rehabilitation from pain-related disability should press on



without fixed limits, while the impairment evaluation process runs a risk of establishing limits and sending a message that the limits are permanent. The treating physician acts as an agent for the patient, but the evaluator should act as an agent of the entity that requires the rating (eg, the state, the court, or an administrative agency). Sullivan and Loeser questioned whether the patient/examinee would be able to determine when the physician who accepts both roles was changing allegiances. They suggested that such dual roles for the physician would require the patient to adjust his or her perception of the physician from an advocate to an adversary (and then adjust back again).

Such role confusion is an issue for the physician as well as for the patient/examinee. Is the physician a treater or an evaluator? Is the individual under study a patient or an examinee? Such confusion creates an elevated risk of exploitation of the patient/examinee's trust, as well as creates a risk of violating that trust.

Sullivan and Loeser further explained that these fundamental differences create a risk of compromised patient care. In this specific case, patients were reported to demonstrate less willingness to reveal information to an evaluator and more willingness to reveal information to a treating physician. Subsequently, the quality of the relationship between the treater and the patient would be compromised if the treater took on an evaluation role because of the tendency for the patient to become less willing to share information.

Sullivan and Loeser also introduced into this discussion the counter-therapeutic nature of impairment evaluation. Impairment evaluation can be a counter-therapeutic process when it gives a message to the examinee that his or her impairment is fixed, and that the rehabilitation effort has ended (or is hopeless). While this iatrogenic risk is always associated with the impairment evaluation process, Sullivan and Loeser pointed out that such risk is elevated when the conclusions of permanent impairment are offered by the treating physician.

In concluding their argument against the simultaneous adoption of such dual roles, Sullivan and Loeser characterized impairment evaluation as a "counter-therapeutic," "non-medical agenda," and as serving legal rather than medical ends. They further warned that the adoption of such dual roles may have the effect of producing or enhancing disability. Given such considerations, they concluded that treating physicians should not become involved in the impairment evaluation process (at least for chronic pain complaints).

## Considerations From Mental Healthcare Literature

In 1997, Greenberg and Shuman addressed similar, but broader, issues with regard to mental illness.<sup>2</sup> They presented a list of differences between therapeutic and forensic roles, and thereby they illustrated the inappropriateness of a treating clinician engaging in any forensic activity (at least in regard to mental illness).

Greenberg and Shuman presented differences between therapeutic and forensic roles. Clinical relationships typically benefit from the clinician adopting a supportive, accepting, and empathic attitude; while forensic evaluations typically benefit from the evaluator adopting a neutral, objective, and detached attitude. The expertise of a treating clinician is rooted in techniques that hold promise of reducing impairment; in contrast, the expertise of a forensic evaluator is rooted in evaluation techniques that are specialized to the administrative and legal circumstances, requirements, and demands. In the treatment relationship, the clinician's understanding of the patient's history primarily is based on information from the patient, no matter how incomplete, grossly biased, or mistaken that information may be; but in the

course of a forensic evaluation, scrutiny is applied to the reports from the examinee in numerous ways (collateral interviews, record review, scientifically validated assessment tools, etc). In a therapeutic relationship, the structure is determined by agreements established between the patient and the clinician, and can develop informally; forensic evaluations may require a great deal of

formal and/or standardized structure in order to make the most efficient use of the limited time that the evaluator will have with the examinee, and other parties (ie attorneys, courts, or agencies) may play a role in the creation of any such structure.

The treatment relationship is rarely adversarial; a forensic consultation frequently is perceived by the examinee to be adversarial. The goal of the treating clinician is to work within the therapeutic relationship to benefit the patient; the goal of the forensic evaluator is to answer referral questions posed by the referring entity. In a therapeutic role, the patient is the client of the clinician; in a forensic evaluation, the examinee is not the client of the clinician, and may instead be a client of an attorney, the court, or an agency. In a clinical relationship, clinician-patient privilege is the guiding legal principle for confidentiality issues; in a forensic evaluation, confidentiality

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*"Treating clinicians may be well advised to avoid forensic activity, regardless of what their specialty might be. They should be aware of difficulties they may encounter when performing impairment evaluation."*

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# Impairment Tutorial (continued)

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issues may instead be governed by the legal standards of attorney-client privilege and attorney work-product privilege. And finally, a treating clinician must carefully avoid doing anything that would threaten the therapeutic relationship, in order to ensure the continued involvement of the patient in the treatment process; the forensic evaluator is free to make any judgments or recommendations with which the examinee might disagree because a forensic evaluator is free from any such risk of compromising a therapeutic relationship.

Greenberg and Shuman concluded that the adoption of such dual roles was an ethical violation that compromised the efficacy of treatment, compromised the accuracy of judicial determinations, and created an elevated risk of deceptive clinical-legal testimony.

Textbook discussions of the incompatibility of treatment and forensic roles have been published by the American Psychiatric Association's publishing subsidiary, specifically in multiple editions of its *Textbook of Psychiatry*.<sup>3</sup> Such discussions have emphasized that "treatment and expert roles do not mix" (for mental illness). These discussions reference the work of Greenberg and Shuman and reiterate several of their key points.

The textbook discussions also present additional considerations. For example, it is explained that a patient should be reasonably liked by a treating clinician ("No practitioner can treat for very long a patient who is disliked"). Such issues of affection compromise hopes of obtaining the type of objective evaluation that a forensic context demands. It also is explained that the treating clinician looks for disorders to treat, rather than introducing sufficient skepticism to recognize when there is no such disorder. In addition, the financial conflict of interest for the treating clinician is highlighted (the treating clinician stands to benefit economically from any recommendation for further treatment, and therefore has a financial interest in the outcome of any legal/administrative deliberations).

These textbook discussions published by the American Psychiatric Association, and the discussion from Greenberg and Shuman that was published by the American Psychological Association, agree that conceivably it is acceptable for a treating clinician to testify as a fact witness. The testimony should be limited to issues such as the number and length of appointments, diagnostic conclusions, and treatment plans. This fact-witness testimony is distinctively different from forensic expert testimony, which can involve discussions of the causation of claimed impairment and the extent of damages (issues which would not be appropriate for a treating clinician to address within a legal forum).

## Broader Implications

The authors of all aforementioned articles have limited their conclusions to the treatment of chronic pain and

mental illness. However, it should be noted that their arguments also have relevance for other specialties.

For example, the financial conflict of interest that is manifested when a treating clinician engages in any form of forensic decision-making is relevant to all specialties. All treating clinicians can benefit financially from offering opinions that a condition is work-related, injury-related, valid, disabling, and in need of further treatment. Treating clinicians often find themselves in a position where they would be cutting off a source of their own income if they were to offer opinions that the clinical presentation is not valid, not work-related, not injury-related, not disabling to an extent that would warrant benefits (such as Medicare), and/or not in need of further treatment. This financial conflict of interest can only be eliminated by reserving such referral questions for independent examiners, and by restricting treating clinicians from becoming involved in such decisions.

As another example, any treating clinician who engages in impairment evaluation creates a risk of iatrogenesis, regardless of what the clinician's specialty might be. As was explained by Sullivan and Loeser, the impairment evaluation process, with its inherent focus on permanent impairment, is counter-therapeutic because it sends a message of hopelessness to the patient/examinee. That message undercuts the patient's motivation for recovery and the credibility of any rehabilitation plan that the clinician might be simultaneously prescribing.

In addition, the risk of a patient being alienated by a treating clinician's involvement in impairment evaluation and/or additional forensic activities is not limited to treatment for chronic pain and mental health. Any treating clinician who engages in such activities, and then presents conclusions that the patient finds unsatisfactory, creates a risk of destroying the therapeutic relationship.

Similarly, impairment evaluation and other forensic activities, when carried out by a treating clinician, have the possibility of compromising the quality of healthcare. To create and modify treatment plans appropriately, the treating clinician must have an accurate presentation of what is going on with the patient. As was reported by several of the authors referenced above, a patient is less likely to be candid with the clinician when that clinician is engaging in impairment evaluation and other forensic activities. For example, patients who know that their treating physician will be conducting an impairment evaluation (which will play a role in any benefit determinations), might be reluctant to tell that clinician about the success they are having with their rehabilitation efforts. Likewise, a patient who knows that the treating clinician will be asked to offer forensic opinions regarding causation (for example, within a workers' compensation context, or a personal injury litigation context), may be reluctant to reveal the aspects of his or her presentation that indicate against injury-relatedness, and may be reluctant to reveal the existence of other potential causes of the presentation (thereby compromising diagnostic accuracy and, subsequently, treatment planning).

Furthermore, the clinical bias of looking for disorders to treat (rather than introducing skepticism to recognize when there is no such disorder) is not limited to clinicians who specialize in chronic pain or mental illness. All patient care specialists are trained with the same bias of offering treatment in response to complaints.

Finally, all treating clinicians owe their allegiance to the patient, rather than to the judicial and administrative decision-makers who are dependent upon impairment evaluations and other forensic conclusions to complete their duties. Thus the decision-makers are in no position to demand accountability from such treating clinicians and cannot reasonably expect objectivity.

Given all of the above considerations, treating clinicians may be well advised to avoid forensic activity, regardless of what their specialty might be. They should be aware of difficulties they may encounter when performing impairment evaluations. All specialties share the same financial conflict of interest whenever treating and evaluating/forensic roles are mixed. All specialties share the same elevated risk of iatrogenesis when these roles are mixed. The mixing of these roles compromises the

quality of care and threatens the viability of the therapeutic relationship, regardless of the specialty of the involved clinician. All treating specialties share the same bias toward offering treatment for almost any and all complaints, rather than engaging in the type of cautious skepticism that is necessary for competent impairment evaluation and other forensic duties. And no treating clinician, regardless of specialty, can offer their allegiance to the judicial and administrative decision-makers who are dependent upon medicolegal evaluations and other forensic reports, when that treating physician has already established allegiance to the patient.

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## Workers' Compensation Benefits (continued)

*Continued from page 7*

In some jurisdictions, the permanent benefit is statutory and has no medical or clinical basis. Examples of the latter statutes are those that:

- Declare a worker totally and permanently impaired if they are blinded in both eyes or suffer major amputations in two limbs.
- Award a fixed number of weeks of permanent disability benefits following certain treatments even though the outcome is perfectly satisfactory to the physician and the patient.
- Limit or disallow awards for certain conditions, such as tinnitus or psychological conditions.
- Determine if an injured worker receives permanent total disability dependent on whether a threshold value is exceeded.

In addition, regulations or case law may constrain or define how multiple injuries can be combined for losses to the body as a whole, or how preexisting conditions should be apportioned to the loss. Some jurisdictions require all impairments to be combined as a single whole person impairment, while others utilize individual impairments expressed as a regional impairment.

## Summary

Several different classes of benefits are paid under workers' compensation. Permanent injury claims account for a very large share of benefits paid. These benefits are largely controlled by medical judgments made by physicians, and are communicated in reports to claims adjusters and workers' compensation administrators. Physician-raters must be cognizant that statutes, administrative rules, and case law are state- or jurisdiction-specific, and at times may seem impractical as one reviews the relative severity of injury for purposes of quantifying benefits to be awarded for permanent injury.

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## Acromioclavicular Joint Arthritis (continued)

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