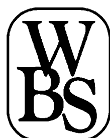

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The independent medical examination

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Defining characteristics of the IME

Purpose of an IME

The independent medical examination (IME) is a tool of dispute resolution, used when the disagreement between two or more parties contains one or more key issues of medical nature. The dispute may be narrow and specific, involving questions of causation, diagnosis, prognosis, or treatment options. The dispute may be wide-ranging, involving long-range care costs or querying fraud.

The role of the IME is to review and analyze, and in some instances update and expand, the existing evidence in order to provide guidance to the parties as to the strength of the medical opinions of the case. The IME report rates the information along a continuum from unfounded speculation through to certainty, for medical knowledge in general, and for the clinical findings in the particular case. The IME report should clearly, concisely, and comprehensively instruct the parties, with the intent that either the parties can find common ground for settlement or the triers of fact will be assisted in making an informed determination [1].

An IME can only fulfill a contributory role if the analysis of evidence and references to fact are logical, impartial, and appropriate. The examiner must fully understand and completely address all suitable questions asked—without regard to the implications of any opinion to either party—in order to assist meaningfully in dispute resolution.

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Relationship of physician to claimant and other parties

Perception is as important as reality in preserving respect for the IME. Central to this goal is the absence of obligation or a priori allegiance to any party, diagnosis, or intervention. An evaluation and report must be impartial, non-judgmental, and without advocacy or conflict of interest (COI). COI may involve direct or indirect socioeconomic considerations. The potential for perceived COI includes circumstances wherein a favorable opinion might have impact directly upon the physician, or indirectly, by extending some advantage to the physician's employers, employees, colleagues, family, or friends.

A potential for appearance of COI does not preclude the physician's providing an IME. However, there must be full disclosure to all parties in advance, and then the parties must agree to proceed. The main problem in most apparent COI situations arises from inadvertency, when incomplete disclosure permits the inference of intent to deceive.

Outcome must never influence opinion. The physician who provides an expert IME opinion must be prepared to accept the realities of litigation: it is inherent in medicolegal dispute resolution that an IME opinion may validate or advance one party's claim—especially if a proper claim had heretofore been inadequately articulated or supported. Often in such cases, if the same expertise had been available to the parties earlier, the dispute might never have arisen or could have been readily resolved. Further, as to repercussions, real-life medicolegal dispute outcomes are governed by a host of factors, including not only medical evidence and fairness but also insurance policy provisions, legal statute and precedent, litigious practices, and the unpredictability of triers of fact.

In performing an IME, given the strong potential for COI, there cannot be a coexisting physician–patient relationship (PPR) with the claimant. Of equal importance, many patients expect a PPR whenever they interact with any physician. As a corollary, they expect the physician to provide advice, care, and a supportive opinion. The claimant must receive adequate explanation of the nature of the IME, in advance of being asked to consent to proceed [2].

Clearly, the absence of a PPR in an IME does not reduce the obligation to treat the claimant, as with any other ill person, in an ethical and professional manner at all times. During an IME, the examiner may identify a medical problem that the attending physician might not be aware of. There is an ethical obligation to communicate this concern to the attending physician, in a fashion appropriate to the level of concern. The communication should be formal, timely, and on point, without any discussion of the medicolegal aspects of the case. A memo should be made, recording the details of any non-written communication (to whom, when, etc).

The purpose of an IME is to prepare and present an expert opinion to the requesting party. Unless required by legislation or prearranged, the examiner has no obligation to discuss the report with the claimant or anyone other

than the requesting party and should refrain from doing so. Office staff should be trained to explain to claimants that further communication is not permitted; the examiner will neither discuss how the opinion was arrived at nor make modifications on request. If the claimant or another party finds an error of fact in the report, or believes that clarification of the opinion is needed, then this concern should be communicated in written form to the referring party, to be passed on to the examiner. Once formally advised, the examiner should promptly, carefully, and fully address the concern.

The examiner should beware of entering into written or verbal discussion of the methodology, reasoning, or merits of the report with opposing counsel beyond mere clarification. Often, the request for such discussion represents a disguised attempt at pretrial cross-examination by opposing counsel.

During an IME, a physician may come to believe that an ill claimant is inadequately informed about his or her own medical condition and/or is not being well cared for. It is improper for the examiner to directly interfere, uninvited, with an existing PPR, other than in the most extraordinary of circumstances. The examiner may choose to convey serious concerns to the attending doctor directly. This should be in written form, entirely separate from the IME report. It may be appropriate to answer with candor a claimant's questions about normal or abnormal findings obtained during the IME. However, directly expressing one's diagnoses or quality of care concerns to the claimant is improper, other than by the most careful and circumspect of methods. An examiner may choose to describe to the claimant the conclusions of concern that the examiner intends to place within the subsequent report (eg, "I intend to put in my report that…").

Conduct of the claimant and others

The claimant can expect to be treated in a fully professional fashion that is sensitive to issues of language, ethnoculture, and related nature. However, when claimants insist on being escorted, out of fear of mistreatment, or wanting a witness to proceedings, or to assist with poor memory, the examiner is justified in resisting (except where legislation governs the matter). A written office protocol should be maintained concerning escorts. It might specify that a child under 16 years of age must be accompanied during an IME by a responsible adult, and that elderly, developmentally handicapped, or cognitively compromised persons should have a first-order relative with them. Claimants with previously demonstrated concerns over the impropriety of a physician in the past should be encouraged to have an escort for reassurance [3].

Only a professional translator should be used whenever communication is a problem. Inherent in the use of a non-professional translator is the potential for inaccurate communication. The examiner must be certain that questions were properly translated and that answers were faithfully related (eg, asked about past health problems, the claimant speaks for five minutes, and the friend then translates with one word: "none").

The physician and his or her staff must be treated with respect, free of any sense of personal danger from the claimant or any other party. This should be enforced with "zero tolerance" for threats, swearing, sexual comments, touching, etc.

The claimant must be informed that there is an obligation to provide maximum effort and full disclosure: that the examiner may comment in the report on misleading disclosures, on any failure to disclose potentially relevant information or to correct misconceptions, or on inconsistent or contradictory disclosures or poor effort on test responses. The claimant must be informed of his or her right to pause or stop the examination at any time if there is excessive stress or pain. The claimant has the right to know the basis for questions that seem to intrude unusually into private aspects of personal life or the lives of relatives or friends.

However, the examiner need not tolerate unreasonably long or tangential or abbreviated responses, or excessive demands to explore the reasons behind questions or to rephrase questions. The claimant must also expect that negative inferences may follow from excessively limited responses or from refusal to respond to reasonable questions after appropriate explanations are given (eg, asking about family health would not be unreasonably intrusive if the patient was claiming an occupational emotional stress disorder but had not disclosed that the father, who lived with them, was recently diagnosed with Alzheimer's) [4].

Faced with persistently inadequate compliance during an evaluation, an examiner should politely caution the claimant, clearly setting out the criteria for assessment termination (eg, You have refused to answer any questions about your past health, although I have explained that the answers are important to establishing cause. I will ask you my questions once again. If you are not prepared to provide this information, I will not be able to do a proper evaluation and I will stop the assessment.).

Scope of inquiry and service

The IME physician must carefully develop an understanding of the underlying medicolegal dispute, the legislated criteria, or policy definitions that govern the determination process, and the rules for report preparation and disclosure. For example, in some jurisdictions, it is obligatory to present copies of the report to the claimant, attending physician, and requesting insurer. In some jurisdictions, an IME for disability determination is not permitted to offer comments about treatment quality, future needs, appropriateness of costs, or prognosis. A court-ordered IME may contain certain conditions or restrictions for the claimant or the physician (eg, the court orders a physiatric examination of the orthopedic system but specifically prohibits a neurologic exam). The examiner should refuse any referral in which proposed restrictive conditions compromise professional integrity or work-product quality [5].

Further recipients of the report

Years after the evaluation, the examiner may receive a request for a copy of the original report or for a meeting to discuss the case from a party to an unrelated or related dispute and/or litigation. The examiner should seek specific permission, ideally in writing, from the original referring/retaining party, prior to releasing any information, in any form.

Quality assurance

Comprehensiveness

The features that determine the quality of an IME include the appropriateness of the scope of inquiry, the depth of detail of both the clinical assessment and the evidence review, and the craftsmanship of the report. Many disputes over the acceptability of an IME turn on the extent to which it was properly conceived and thoroughly carried out. Since most medical problems are to some extent multifactorial in either origin or basis for persistence, it is clearly necessary to develop a proper breadth of appreciation of the person as a multidimensional entity living within the real-world context of family obligations; recreational, social, and volunteer activities; and vocational responsibilities. Similarly, a proper longitudinal perspective is needed for appreciation of premorbidity/comorbidity, which includes not only negative but also positive predispositions in meeting the challenges of ill-health and impairment.

Time spent and deadlines

A common challenge to the value of an IME is that the clinical assessment was too brief and thus inadequate to develop a proper appreciation of the claimant and his or her problems. This begs the question of how long one should spend in interview and examination. Contrary to lay expectations, there is no defined standard beyond peer or case comparison. Although it may seem to be a circular argument, the time required for a clinical assessment is the time required to complete all necessary interview and examination. To some extent, duration is case-specific, never absolute. On a relative scale, a potential yardstick is found in considering case complexity and claimant attributes, as well as examiner skills and experience. It is often surprising for the court to learn that an assessment for quadriplegia may require less time than that for a chronic pain syndrome.

The amount of time spent on conducting an IME should never depend upon unreasonably tight bookings or whether one is running late. It is the obligation of the IME physician to allocate the resources of time and effort necessary to perform all essential elements of assessment, so as to achieve a fully informed conclusion. The actual assessment component times (interview

start time, breaks, exam start, end time) should be carefully recorded against the possibility of later questions.

It is appropriate and even advisable to inform the claimant, in advance, when the history is likely to be more important than the examination, so that time spent will be apportioned accordingly. Also, it is useful to tell a claimant which body systems will be examined and generally how long the examination takes for the average person with a similar condition. The heightened stress of an evaluation usually leads to a misperception that less time passed than was actually the case. Claimants who believe that the evaluation was properly planned and carried out are less likely to question apparent brevity.

It is often helpful to end the assessment by asking the claimant about omissions or commissions: if there is any area of inquiry or any examination test which was not done, any new or worrisome testing, or any other concern about the assessment. Not only is this a good quality-control measure, but it also creates a basis for responding to any subsequent claimant challenge that the assessment was inadequate in time or scope.

Specific timelines and deadlines should be created and respected for the entire IME process. The history and physical examination should be written out or dictated within 48 hours to avoid recall decay; this is inevitable, especially when there are other cases interposed. Optimally, the complete report should be ready for final proofreading within 2 weeks, since there should still be fairly good case recall within that period. The final report should be released within 60 days of the assessment [6].

Knowledge

At intake, the physician must candidly question whether the referral is within his or her scope of expertise and should be accepted. The mere fact of having specialist certification does not make one an expert with respect to all conditions. A recently read article is not a substitute for the familiarity of experience.

One must consider whether an effective interview and examination can be done with that claimant, and whether the final report will be suppositional or firmly based in first-hand clinical knowledge. Always remember that these tests of judgment may be reviewed under circumstances of aggressive cross-examination.

Impartiality

It is normal for physicians to be drawn to certain polarities by virtue of their training, experience, and personality. This can lead to advocatorial feelings toward victims of certain conditions or to a concern over the predominance of societal rights. For example, an examiner with a special concern over the lack of societal recognition and support for head-injury

rehabilitation may have difficulty with suggesting malingered pretense in a claimant whose history is equivocal for head injury but whose presentation of cognitive impairment is dramatic. An examiner, having seen a large number of somatizing patients, may have difficulty giving credence to arguments over traumatic, organic cause in chronic pain claims.

There are two practical approaches that IME physicians should consider. The first is to recognize one's partiality and to refuse IME work involving pertinent medical conditions. The second is to declare one's bias at the outset, then ensure that the report contains a careful analysis of why any seemingly a priori conclusions are not merely reflective of bias.

For the physician there can be inadvertent perceptual distortion, with partiality, as encapsulated in the axiom: "For the carpenter, all is nails." The same symptoms may suggest differing diagnoses, depending upon the specialization and clinical experience of the doctor. For example, chronic fatigue may be considered post-viral (internist), a fibromyalgia equivalent (rheumatologist), or a depressive equivalent (psychiatrist).

Ethics

The IME requires a standard of ethics at least as high as that expected in daily medical practice. Malpractice claims aside, no other portion of a physician's practice will come under as aggressive scrutiny as the IME. Every word said by staff or doctor, every document sought and reviewed, every choice made and every test performed will be reviewed in an effort to find fault, thereby invalidating the report. One must be meticulous in ensuring that there is proper respect shown to the claimant and that a complete assessment is carried out, with careful documentation of the process [5].

Adherence to routine (level playing field)

Standardization of approach both ensures and demonstrates a lack of partiality. In a routine protocol, the same core questions are asked, and the same core tests are performed for all claimants with similar conditions. This neutralizes accusations of "trying to make the claimant look bad," or "controlling the outcome," by either commission or omission. As a corollary, this prevents inadvertent shortcuts, such as exempting certain claimants from tests of response bias to establish validity and reliability (eg, Waddell signs, documentary corroboration of history, etc).

In some cases, inadvertent bias is prevented by performing the clinical assessment in advance of any review of the medical file, other documentation, surveillance, etc. However, another examiner might well believe that, without being fully briefed, the IME will be inefficient, and important areas of inquiry might not be explored. It is important that each examiner design and adhere to an IME protocol that considers efficiency and bias. If one deviates from a protocol, this should be noted within the report, along with

reasons. For example: "It is my routine protocol to assess a claimant before reviewing the file, and to have no family or friend present during the assessment. Early on, it became apparent that the claimant was a vague and inconsistent historian, the complaints being illogical and developments chronologically implausible. I sent the claimant out for a coffee break, read through the key elements of the file, and then invited the claimant back. Her husband was invited to join us and to contribute fully."

Record keeping

The IME conclusions must be consistent to the evidence used, and the report's statements concerning interview and examination consistent to the clinical records made. The IME physician must not only be competent but also must appear so. The records of interview and examination should be detailed, indicating the scope of questions asked and the nature of answers given. A record that lacks notations about a certain test can attract the challenge that the test was not done or that the results were other than as reported. Should the notes indicate a response or test result that is not mentioned in the report, the examiner may be accused of purposeful "cover-up." As a guideline to note-making, use abbreviations carefully and consistently, and paraphrase or quote key responses [7].

A series of close-ended checklist questions ensures that key history is consistently explored. Responses must be noted. For example, if a checklist on health history is used, place a copy of the checklist in the file, and note each response, unless all items were answered with the same answer (eg, regarding orthopedic past health, including physiotherapy/chiropractic/orthopedic consults, NSAID treatment, spinal X-rays—all answered "no").

Under no circumstances should records be tampered with after the fact. An untouched record can be dramatic proof of the veracity of a claimant or the capability of the interviewer.

Preliminary phases of the IME

Screening of referrals

Before one formally accepts the assignment of independent medical examiner for a given case, it is important to determine if the case is appropriate. It is prudent to have one's staff carry out a routine intake screening. An intake form might require such information as the type of case, the questions being asked, and the time frames for completion, among other factors. It is generally preferable to have the IME clinician speak directly with the potential retaining party to ascertain the appropriateness of the referral, in the context of whether the work falls within his or her experience and domain of expertise. Additionally, and as appropriate, policies regarding report preparation, such as the potential paradigms for consultation (eg,

peer review, trial consultant, IME, treating physician), the absence of draft versions for retaining party review, and IME ethics should be discussed by the practitioner and the retaining party at this phase of the relationship.

Third-party contract

Once an assignment is accepted, then some type of letter and/or contractual agreement should be signed by the retaining party, obligating them to the policies and fee structure of the consulting examiner. Contractual agreements are a sound way to ensure not only that one gets paid for the work that one does (although such measures do not guarantee this) but also that one's ethical and medicolegal policies are specifically delineated.

Claimant orientation

When introducing oneself to a claimant, it is important to try to minimize any anxiety that may be present in the context of an independent medical examination. Clearly, depending upon the circumstances under which the claimant is present, motives with respect to effort and truthfulness may vary across a broad spectrum. When a claimant is present for a defense IME, he or she will tend to be anxious and guarded, with a propensity to ensure that the examiner understands his problem. In the context of a plaintiff IME, there will generally not be the level of guardedness and/or emotional stress that is present in a defense IME context; however, given the potential for secondary gain, there may still be issues of response bias that need to be addressed by the examining clinician [8].

It is important to encourage the claimant to provide the most accurate reporting possible, with the stipulation that your job as an independent medical examiner is to advocate only for the truth and not for any party involved in the issues at hand. One must convey that the best way to achieve this is to have the claimant provide the middle-of-the-road story, neither amplifying nor minimizing problems [9].

Clearly, it is important to make sure claimants understand the context in which they are being evaluated. An up-front review of who the referring party is and the purpose for the referral is critical in any IME. Additionally, examiners should note the absence of a PPR and the implications relative to the lack of any claimant–examiner confidentiality. It must be made clear to the claimant, up front, that the examiner is not there to provide direct clinical treatment recommendations, and that such recommendations, if made, would be conveyed directly to the retaining party [10].

It is important to provide information to the claimant that serves to not only protect the claimant but also the examiner, regarding the need for the claimant to inform the examiner should be there be any significant discomfort or pain during the exam. The claimant should be informed that, should he or she need to take breaks, owing to fatigue or pain interfering with performance, he or she should inform the examiner or one of the staff members.

Many examiners provide their claimants with a short introductory summary regarding the IME (or even an IME agreement) that stipulates some of the aforementioned matters. Once the initial phase of the IME is completed, the examiner should review, in summary fashion, the scope and content of the IME to be conducted. If the claimant is to have various assessments by different individuals, potentially at different sites, this should be made clear, up front. The order of the evaluative process—assuming it includes more than one clinician and/or evaluator—should be determined. Various testing formats should also be discussed (eg, written forms, computerized assessments versus functional capacity evaluation). The scope and detail, in terms of the examiner's direct contact time with the claimant, should also be reviewed.

Evaluation phase: interview

Interview structure and goals

Often much of what we need to learn from a clinical assessment is derived from how the history is presented [11]. That is, it may be as or more important to understand how the person has responded to the impairment than merely how the impairment was acquired and what is the extent of impairment. An effective interviewer utilizes observation and conversation. This approach is compatible with the axiom that non-verbal communication provides 75% of the information transferred between humans during any interaction.

As a corollary, it is essential that the IME physician hone his or her interview and observational skills. An initial interview goal is to ensure that effective communication will occur. Parameters requiring consideration include the emotional and cognitive state of the claimant, language skills, and any elements of interference, such as level of arousal, medication level, etc.

It is a proper subject of cross-examination to explore whether the answers given were provided under suitable conditions, thereby ensuring validity. A notation of the claimant's demeanor as alert, detailed, and decisive may be relevant when, for example, the claimant later asserts that she had inadvertently overmedicated after a bad night's sleep and had been unable to understand the questions or recall relevant information about prior ill-health.

If there is any doubt about the claimant's ability to understand and to respond in the same language as the practitioner, a professional translator must be used. Using a claimant's friend or relative as translator opens questions of capability to accurately and fully relate information. Also, a claimant may be inhibited in responding in the presence of a friend. Moreover, a relative or friend may wish to advocate by altering answers for effect.

Asking strictly open-ended questions creates potential for inadvertent errors or purposeful distortions. Using a thorough set of close-ended questions is apt to reduce the potential for error. For example: Q [open ended]: "Have you ever had a back problem?" Q [close ended]: "So, may I assume that you have never complained to your doctor about back pain or sciatica;

you have never visited a physiotherapist or chiropractor; you have never had back X-rays or a CAT scan or MRI; and you have never seen a specialist in orthopedics, physiatry, neurology, or rheumatology?"

Biography

Family structure

Most of life's stresses arise in the family domain. Typical questions involve marital status and information about spousal and children's health. In the case of separation or divorce, it can be important to ascertain the underlying reasons or continuing dispute, and timing of separation or final judgment. It can be important to learn the make-up of the domestic unit, which may include a live-in parent or a grandparent who is able to help or requires assistance.

Domestic circumstance

Basic questions involve the dwelling, including some details of the size and layout, required stairs, number of bedrooms, where the claimant sleeps, and extent of appliances (eg, furnace, dishwasher, etc). It is important to learn if the home has been or can be modified to accommodate to impairments. The history of residences is often relevant to appreciating whether and why moves (a stressful undertaking) were made after a trauma. For example, after developing chronic fatigue, a claimant would not likely decide to search for another, larger home.

Family health

Immediate family

It is critically important to establish that all members of the immediate family are well. The demands upon a claimant's physical and emotional health and time are directly affected. For example: The claimant's spouse has had a recent stroke and requires constant attention, including assistance with transfers and dressing, which could be relevant to the claimant's chronic orthopedic pain, depression, or claim of inability to return to work after a minor MVA.

Other dependants

Illness or infirmity in first-order relatives, such as parents, will usually generate significant stress in the family. For example, the need to take a relative who has been diagnosed with cancer to her doctors' offices or to chemotherapy treatment, and to assist with shopping and cleaning the home, may be very relevant. Occasionally, inappropriate reverse dependency will be discovered through this inquiry.

Genetic patterns

Many chronic health conditions have a genetic component, with overrepresentation in certain families. The expression of the condition may vary

in intensity. Suspect conditions may include substance abuse, diabetes, depression, obsessive-compulsive disorder, and fibromyalgia. The presence of a predisposing genetic risk factor may help to explain why the claimant has become ill. This does not reduce the importance of an unmasking provocation "but for" which the condition might not have emerged.

Pre-event history of health, education, work, military, incarceration

Past health

This inquiry requires meticulous, detailed exploration. Who is the current family physician? Who was the physician before the MVA? If there has been a change, when and why did it occur? Changes of physician may signify a desire to hide important health history by "starting fresh"; or doctor-shopping for better care, or for narcotics, or perhaps for more supportive reports.

Lack of full disclosure of the extent of health problems may signify volitional deception, lack of insight, or selective memory-blocking; not infrequently, patients idealize their past physical or emotional health, psychosocial, vocational, or economic circumstances [12]. As a corollary, the patient and the practitioner may set unrealistic and unattainable recovery goals, leading to extended interventions, prolonged litigation, and a frustrating perception of failure and chronicity. Notably, claimants who have recovered from depression may not accurately recall or appreciate the extent of their recent emotional illness and disability.

Education and work

Meticulous and detailed inquiry can help in developing an understanding of the strengths, weaknesses, and interests of a disabled claimant. Often, there is direct relevance to the potential for successful vocational rehabilitation. For example: A 25-year-old construction laborer suffers bilateral lower leg amputations. He was working on an MBA by correspondence, while supporting his elderly parents through unskilled construction work.

Other life experiences

Guided by chronology, it is necessary to develop a full and reasonably detailed review of significant components of the claimant's life, including military career and injuries or illnesses while serving. Inquiry into incarceration may be relevant to concurrence of stressful court activities and periods of unavailability for rehabilitation. It may be of benefit to learn of volunteer work, such as coaching, or of special service, such as foreign-aid work.

Interview: traumatic event and urgent-care history

Immediate background

It is valuable to briefly reiterate and confirm the understanding of the antecedent circumstances developed from the narrative preaccident history. The

examiner should be concerned about any incomplete confirmation from the claimant. For example: The claim concerns a disabling post-traumatic depression, following a minor MVA. The claimant described preaccident work as stable, full-time, and enjoyable; and health was excellent. Upon reiteration, the claimant was noted to be evasive about confirmation. To further questioning, the claimant disclosed that, at the time of the event, he was on compassionate leave to care for a parent whose advanced cancer required continual care in the claimant's home.

It can be of special value to complete this reiteration of the general situation by inquiring about the situation that day/week. For example: The claim involves a work lift injury with discogenic left sciatica, including loss of the Achilles tendon reflex. It is learned that the claimant had, early on the morning of the accident, undergone a medical exam for life insurance purposes, with the medical exam including reflexes. The exam record will be pivotal in establishing whether the absent reflex finding preceded the work accident.

Physics

Physicians are not physicists. It behooves the examiner to gain a useful appreciation of the nature of the precipitating event, but at the same time to recognize limitations of competence. All too often, doctors make their judgments on the basis of collision repair costs. There is cause for concern at either extreme: 1) being dismissive of claims of injury for a $50 repair and 2) being uncritically accepting of claims of injury with a $25,000 repair. However, occasionally, a vulnerable individual (eg, osteoporosis, elderly spine) may sustain fracture or cord contusion in a trivial collision. Equally, for many expensive European cars and for most motor homes or SUVs, even minor collisions can be very expensive to repair.

With experience, many examiners become proficient at considering general rules of automobile design and physics. A fuel truck weighing 50,000 kg and moving at 100 km per hour will not experience substantial deceleration when striking a glancing blow to a parked car. Also, cars are designed with an "energy cage" around the occupants, and with bumpers and crumple zones designed to extend the post-impact acceleration phase (Δt) and reduce acceleration by dissipating collision energies (Δv). Air bags can be protective in high-velocity collisions but sometimes deploy in minor collisions and may even cause death. Seat backs are designed to "fail" to protect occupants.

Beware of the physician who concludes that an accident "caused" a medical condition, when inadequate medical history and event details are ascertained, or when the extent of knowledge of collision physics required in the analysis exceeds his or her credentials.

Kinematics/biomechanics

Of even greater importance to the occupant, and thus to the examiner, is the effect of collision energy on the occupant. For example, research has

consistently shown that, during low-velocity collisions (LVC), there is no serious energy transfer, and tissue-injury thresholds are not reached. Volunteers subjected to collisions—in parallel to collision derby drivers—do not develop significant or prolonged injury symptoms. The kinematic study of the LVC demonstrates that the phenomenon of whiplash, with the head snapping back into hyperextension, does not occur; instead the body and head ramp up the seat back, without substantial flexion or extension. In parallel, high-velocity kinematic video and simulated-motion studies have shown deformations of the human body—which predict injury—that were not anticipated from earlier theories.

The examiner must ask about body motion but must also avoid placing excessive reliance on anecdote. The examiner must develop an adequate awareness of the available scientific knowledge and must use indirect information, such as seat belt-bruise pattern or ambulance records. For example, in minor rear collisions, the occupant's knees typically do not move forward into the dashboard, and the head is not markedly accelerated, so claims such as dashboard knee syndrome or loss of consciousness require careful consideration.

Pathology

Ultimately, all anecdotal recountings and hypothecations require correlation to the clinical features. The analysis of physics and biomechanics must serve to explain the objectively demonstrated injuries. Just as an "abnormal" spinal MRI is irrelevant in the context of an asymptomatic and objectively normal patient, a forceful collision which causes occupant ejection is not incompatible with an individual "walking away without a scratch." Also, even in minor collision circumstances, a few patients may sustain catastrophic injury. The examiner works "backwards" from the clinical pathology, seeking explanation in the physics and biomechanics. Some physicians and lawyers work "forwards," developing an expectation of serious injury from their reactions to some aspect of the collision event, such as collision damage. This must be decried. Moreover, such faulty logic will be suggestive, creating expectation in some patients that, given the forces involved, they must have been injured, even though there is no evidence of injury. Adverse consequences—all too often seen—include iatrogenic injury neurosis (akin in mechanism to mass hysteria).

Immediate care—ambulance and emergency room, GP, and dentist

Proper appreciation of the plausible long-term consequences of a traumatic event begins with meticulous assemblage and careful review of clinical information about the acute sequelae, which, in the main, are rapid in onset and objectively most dramatic early on. Many inappropriate claims of severe long-term impairments do not survive careful scrutiny of the evidence about an event's physics and biomechanics, especially when there is good correlation to initial clinical records. The opposite can be equally true.

Interview: postevent history and sequelae

Background information should be acquired regarding the postinjury and/or illness recovery course, with respect to changes germane to impairment and disability, as well as handicap. As possible, the examiner should try to determine what medications the claimant has been treated with over this healing phase, as well as the specific duration of treatment and dosage of medication. The latter factors are important in determining whether an individual has received adequate courses of medication to optimize the therapeutic clinical response for the injury-related problems. A review of diagnostic testing during this time period is also relevant to understanding the pathologic, as well as physiologic, basis for reported and observed impairment and disability. Historical factors dealing with current and projected treatment should be delved into, as they are relevant for understanding an individual's current clinical and functional status. The examiner should request of the claimant details regarding functional abilities and limitations related to activities of daily living (ADL), mobility skills, communication abilities, bowel and bladder function, sexual function, cognitive and behavioral function, driving, as well as avocational and vocational activities.

Potential secondary gain issues (including litigation/workers' compensation) should be explored, as these may be relevant to potential response bias on the part of the claimant [13]. Incentives for return to work, as well as disincentives, should also be part of a more detailed interview process. Individuals who have strong incentives to work may minimize impairment and/or disability through "simulation" of good function (fake good). On the other hand, individuals with disincentives—financial or otherwise—for returning to work may dissimulate (fake bad) in an effort to avoid work and/or earn higher financial rewards [14].

One of the authors (Zasler) regularly asks claimants how much they feel their case is worth. The question is asked (to the general chagrin of lawyers) to establish some sense of the particular individual's focus on litigation, and whether the claimant has realistic expectations of the litigation process. Understanding what an individual perceives he has to gain through litigation, in terms of both quality and quantity (the latter in a financial sense), may provide insight into other behaviors noted in the historical review of a case and/or within the confines of the independent medical examination process.

The other author (Ameis) takes a related approach, asking the claimant to describe in specific detail how proceeds of litigation will be utilized to improve the claimant's quality of life. Often, this provides insight into knowledge of illness, practicality of expectations, and extent of ADL difficulties. A wide gulf separates the self-gratifiers from those focused on restoring independence. In the former example, one might hear a claimant speak of treating himself to massage therapy, and of buying a big house and fancy car to compensate himself for pain and suffering. The expectation for settlement is large but non-specific. In the latter example, there may be discussion

of hiring a private trainer to facilitate a higher level of fitness for independence, of remodeling to outfit a fitness room at home, and of buying a large car to give a greater sense of security when driving. The expectation for settlement may be larger but tends to be carefully thought out and itemized.

It is important to understand how well educated a claimant has become regarding his diagnosis and treatment, through reviewing educational materials from treating physicians or other individuals, including advocacy organizations, or through his own efforts at self-education regarding his disease and/or condition. Many patients/claimants now go to the Internet as their primary source of information and have a plethora of information as a result of "computer consultation." Some of the information may be helpful to some patients; however, it can also misinform, create unwarranted fears, or promote disability in a litigious or emotionally vulnerable claimant.

The examiner should have a full understanding of the specifics of the rehabilitation efforts that have taken place during the claimant's postillness/postinjury treatment. Among the most important areas to explore is what adaptational and/or compensatory strategies the claimant has put into use as a result of the rehabilitation process and/or through self-taught strategies. When assessing these issues, it is fairly crucial to determine the claimant's compliance with the recommended treatment, and the utility and energy efficiency of the particular strategies being utilized.

Evaluation phase: examination

A thorough IME includes a detailed assessment of the body systems that are reportedly primarily involved in the illness/injury-related impairment and/or disability, in addition to a general screening examination. In the context of a physiatric IME, the systems that are most frequently involved are the musculoskeletal and neurological systems. When there are both neurologic and musculoskeletal issues, the duration of the examination is inherently longer. The complexity of the assessment must be taken into consideration when scheduling the IME [15].

Many clinicians feel it is important to get baseline information from the claimant through the use of questionnaires and/or other test batteries (eg, computerized testing), which may include assessments for pain, psychoemotional status, and/or general functional status. Clearly, when collecting data—whether by questionnaires, computerized testing, or direct physical exam—the examiner should always look for response consistency, and utilize measures of claimant effort. Just as critical, examiners must be familiar with and utilize test methodologies that have documented validity and reliability [16].

What determines an adequate assessment is certainly open to opinion, depending upon the type of patient being evaluated. As an example, many people would argue that a standard Mini-Mental State Exam is an inadequate tool for assessing mental status in someone with a history of mild

traumatic brain injury. Similarly, the presence or absence of pain on sacroiliac joint provocative maneuvers may not be a particularly valid methodology for determining the presence or absence of SI joint dysfunction/pathology. However, there is little disagreement within the neuro-orthopedic specialty community that a proper evaluation for a claim of sciatica includes bilateral assessments of leg sensation, girth, power, and reflexes, and straight leg raises, in both cued and non-cued manner.

Documentation review phase

Converting an assessment into an evaluation

A comprehensive medicolegal *evaluation* is the end point of a relatively long process. The examiner must combine the clinical assessment (consisting of an interview and a physical examination) with a thorough review of documentation, and the report must provide conclusions that comprehensively consider all of this information and factor in one's training, experience, and literature. All questions asked must be addressed.

No evaluation is complete without a careful review of relevant documentation. The reviewer will develop an appreciation of the findings, conclusions, and views of caregivers and other examiners. There may be important differences among several caregivers in the histories taken, findings made, or conclusions derived. There may be agreement or discord to the examiner's own record of claimant narrative history or physical examination. Since medicine is an art as well as a science, there will always be areas of reasonable difference of opinion between clinicians. However, there should not be any significant discrepancy in physical findings or in core narrative history.

The indexed brief

The review of documentation is a phase of inquiry that uses as its starting point the material provided by the referring party. The examiner must insist that the material be indexed by the referring party, and must verify that there is a precise match of documents to the index. As a complication of failing to carry out this basic correlation, consider the consequences of reviewing an incomplete brief. The referring party (and other reviewers) may assume that your opinion was based on the full set of materials described in the index, including material that you did not in fact receive for review!

Timing

The evaluator must either follow a fixed protocol or make a case-specific decision as to when the documentation should be reviewed. Prereading of records of treating practitioners and lab tests may facilitate the interview. Reports from other independent evaluators may contain hearsay or strong

opinion that could bias the examiner before the initial interview. Conversely, this material might contain examination findings and observations of behavior relevant to the current physical examination.

Having advance knowledge of the claimant's statements to others, it may be of benefit to revisit some discordant or confusing statements with the claimant, either during the interview or in a supplementary interview after the physical examination.

Comprehensiveness of the provided brief

In addition to ensuring that the documentation provided matches the referring party's index, the examiner must critically appraise the material's completeness. It is not uncommon for the referring party to be selective in the disclosure process. This may innocently arise from the intent to keep the brief's size readable or pertinent, but laypersons may not appreciate the relevance of some material. The examiner is the ultimate judge of the relevance of any component of the medical database. Unfortunately, some referring parties are more deliberate, seeking to influence the opinion of the evaluator through a careful selection of disclosures. The evaluator must always define the scope of material as either preferable or necessary. This scope must be outlined within the report, and the evaluator must indicate whether the current brief is sufficient to permit completion of the documentation review process. The evaluator must be prepared to decline to complete the report if critically important material is not made available.

Supplementation by adding existing undisclosed documentation

In "requesting" supplementation by material that is *desirable* or *preferable*, there is a direct implication that the contents are not critical to the completion of a report that includes a fully informed conclusion that can be stated and defended without reservations. On the other hand, a request for material which is *essential* and thus *required* signifies that it must be obtained and that, if not obtained, then a conclusion may not be fully informed and cannot be stated without reservations. The report cannot be completed. A necessary corollary is that once the evaluator takes the position that certain further material is essential and required, the evaluator must not complete the report unless and until there is adequate compliance.

Clinical data creation

It is not uncommon for the evaluator to discover that deficiencies in the database arise from lack of caregiver completion of planned testing or of treatment trial, or from lack of appropriate caregiver expertise or suitable tests or treatment. Again, the criteria to be applied involve either desirability or requirement. Is further consultation, investigation, or therapeutic intervention essential? For example: A claim of disabling, idiopathic, chronic

fatigue syndrome centers on refractory symptoms of severe sleep fragmentation and deprivation, with profound daytime hypersomnolence. However, no sleep laboratory study has ever been done and no sleep specialist has been consulted. In compliance with the requirement of the evaluator, a sleep study is done, a remediable obstructive sleep apnea is discovered, and with appropriate treatment, the fatigue and disability are substantially resolved.

Surveillance

Equivalent to "an FAE in the wild," surveillance is yet another clinical tool. It is unprofessional for an evaluator to decline to review surveillance or to review only portions. Investigator narratives must never be used without direct access to the actual video. True, much surveillance information is irrelevant, but only the evaluator can assess the clinical significance within the context of what the history and physical examination predict the level of activity to be. For example: After a horrific MVA, the claimant is said to have sciatica, PTSD, chronic headache, photophobia, and chronic pain leading to full work disability, with enormous economic hardship. On surveillance, the claimant is seen limping and carrying only small parcels, with apparent difficulty. The extent of effect of the sciatica is confirmed. However, the claimant is driving a new, expensive convertible; she is filmed driving on several sunny days with the top down, for long periods, and in aggressive fashion. Subsequent inquiry discovers that, despite continuing physical impairments, the claimant has not disclosed to the insurer that she has a high-paying job and has told her psychiatrist that she has recovered.

There are two schools of thought on timing of surveillance review. Screening before the assessment may engender bias, by virtue of the implication that surveillance is only done on the guilty. Also, it may be a waste of time if the reviewer does not know what activities might be relevant. On the other hand, review immediately after the assessment is efficient: the facts are freshly in mind and contradictions between either the claim or the presentation and the video will be easily discerned.

The issue of bias is obviated if the protocol calls for a completion of the evaluation report, including a statement of conclusions, prior to any video review. However, waiting to watch the video after the assessment may preclude asking the claimant questions that might lead to clarification and reconciliation of the contents of the video. Some evaluators will invite the claimant to review the video, in order to obtain an explanation from the person directly. In some jurisdictions this is a requirement if the surveillance contents are to be referred to in the report and used in the development of final opinions.

Requesting special documentation

The following special documentation may be helpful or even essential to developing a fully informed opinion. The evaluator should not hesitate to request or demand this information when indicated.

1. Driver's licenses, driving records, and renewal form declarations (eg, in a claim of PTSD, there should be no record of citations for speeding, reckless driving, etc)
2. School records (eg, premorbid intelligence tests or records of behavioral problems may be pertinent to assessing head injury sequelae)
3. Employment attendance and performance records
4. Employment health records
5. Refugee records—declarations/medicals (eg, for a recent immigrant, this may be the only available premorbid medical history)
6. Pharmacy records (eg, quite often, patients do not recall or accurately report their medication names, dosages, durations, prescriber sources, and actual consumption levels)
7. Life/disability insurance—application declaration/medicals (eg, the date of onset of a change in health may not be reflected in a family doctor's records when there is infrequent attendance; however, a medical examination for life insurance may provide a reference date when good health prevailed)
8. Preemployment screening—declarations/medicals
9. Military medical records
10. WCB and LTD claim records
11. Unrelated civil litigation—medicolegal records and reports (eg, a claimant asserts that all sequelae from a prior MVA had resolved just before the next MVA; however, reports required for the prior litigation, and developed from medical exams just before the next MVA, indicate a state of severity and chronicity)

Report preparation

There is often debate about how detailed an IME report should be. It appears that the majority of the requesting parties are most interested in the "meat" of the report, which tends to be the last few pages involving impressions and recommendations, causality and apportionment conclusions, diagnoses, and medical and vocational prognoses. It is critical in delineating impressions to differentiate facts from conclusions or professional opinions. Within the latter domains, one should differentiate statements made with medical probability (greater than 50% chance) versus possibility (less than 50% chance). Ideally, examiners should differentiate among impairment, disability, and handicap in the context of providing their forensic opinions [4]. Oftentimes, examiners are requested to rate impairment, which can be done in several ways, although the "gold standard" has become the *Guides to the Evaluation of Permanent Impairment*, published by the American Medical Association [17].

Most examiners will provide and discuss opinions germane to "causality and apportionment": terms each and every examiner should be intimately familiar with in the medicolegal context. If an impairment is causally related

but not fully apportionable to a given injury or disease, then the examiner is obligated to stipulate this fact in his report.

Typically, examiners will also include opinions on maximum medical improvement (MMI), as related to the major impairments being assessed [18]. Other important areas for consideration include comments regarding prognosis, including ability to return to gainful/competitive employment, and life expectancy, the latter particularly in catastrophic injury cases.

Practitioners should be aware of the role of the IME and its limitations in making determinations of return-to-work capacity, including implications of functional capacity evaluations (FCEs) [19].

One has the option of dividing impressions into injury-related/noninjury-related versus questionably injury-related categorizations. Different examiners have different means of expressing their general opinions. As there is a need to expound on specific issues germane to the case, one can always include an additional "general comments" section in the report. If there were specific questions asked by the retaining party, these should be answered in as specific a manner as possible.

Some examiners endorse the idea of having a signature on any text page that includes conclusions or opinions, to avoid pages being substituted or altered. Although there are numerous ways to streamline report production, using such items as macros, boilerplates, and templates, a report that is too mechanized can lead to "not seeing the forest for the trees," and therefore should be avoided.

Testimony

Answering the questions asked

Physicians called to depositions, arbitrations, or court should have no fear of the process. The legal system requires the assistance of the medical practitioner, and usually this is reflected in the doctor being treated with respect and consideration. Most exceptions to this circumstance are brought about by the physician's lack of insight into the process or tendency towards advocacy, inflexibility, or argumentativeness.

The first rule of effective witnessing is to listen closely to each question asked and then to follow this with a moment of reflection in which a concise, clear, and specific answer is formulated. Answer the question asked. Do not allow counsel to cut you off if you have not finished your answer (if your answer is on point). As an advisor to the court, you should not shape your answer toward either "side." Do not argue. You know what you know.

It is important that you prepare yourself before court. Read your notes and reports thoroughly. Ensure your knowledge of pertinent literature is up-to-date. If you have commented on the reports of others, ensure that you are fully reacquainted with these reports.

Do not guess. Do not speculate without indicating that that is what you are doing. You should indicate when you are uncertain of the correct

answer. When asked to comment on hypothetical issues, emphasize that your answer addresses only this specific hypothetical instance. Decline to deal with the hypothetical if you feel too uncertain.

Do not make jokes. Do not allow yourself to get angry at silly, plodding questioning. Do not offer answers that you do not believe in, merely to facilitate ending your appearance [20].

Dealing with cross-examination

A central purpose of the cross-examination is to test your certainty, your knowledge, and your experience. Your opinion may be the main obstacle to one party gaining compensation or to the other party's avoidance of paying compensation. Not surprisingly, the cross-examination will have as its purpose the discrediting of your opinion. The attack must be on what you have said or on who you are. Either your opinion is wrong or else you are someone to whom the triers of fact should give little weight.

Cross-examination will attempt to show that your opinion lacks factual basis, relies on inferior sources, or is overly subjective. An attempt may be made to have you lose your temper, or to become confused, or to otherwise lose your image as a professional. Listen carefully to all questions. Think through your answers, taking as much time as you need. Do not allow yourself to be rushed. Never answer overly complex or confusing questions. Restate the question at the outset of your answer, to make it clear that this is what you understand the question to be and that this is what you are addressing. Do not volunteer information. Keep answers simple whenever possible.

Avoiding advocacy

The single most important error made by physicians is feeling an obligation to a party and attempting to argue for that party's position. The court looks to you for serious, impartial, expert information. The court expects you to be flexible in the face of new information about predicate assumptions, and candid about differences of opinion over diagnoses, caregiving, investigation, and prognostication. Medicine is an art, as well as a science. There are many reasons for colleagues to disagree about the interpretation of seemingly identical evidence. Do not attack your colleagues' professionalism, but do critique their work when you disagree with it.

Understanding objections

Counsel may pose a question, during examination or cross-examination, which is factually incorrect, leading, or otherwise improper. When an objection is raised by opposing counsel, it is being addressed to the judge. Do not say another word, pending the two sides presenting their points of view and the judge then ruling. Listen carefully and follow the judge's instructions

fully. Under special circumstances, you may object to a question directly to the judge. You must then be governed by the judge's response. For example: Under cross-examination, an attending physiatrist was asked to state the anticipated mean lifespan of the quadriplegic claimant, who was in the courtroom. The physiatrist turned to the judge and objected to answering the question in the presence of the claimant, being apprehensive of worsening an already severe depression. The judge agreed and asked the claimant to wait outside.

Finishing your response

Cross-examining counsel may ask a question that leads you to provide an answer that counsel did not anticipate and does not want the jury to hear. Counsel may cut you off by a dismissive comment or by asking another question before you are finished with your response. Be patient and calm, and continue with your response. If necessary, inform the judge that you do not feel you have completed your response. The judge will usually instruct counsel to permit you to finish.

Explaining and substantiating your opinions

The triers of fact depend upon you to teach them what they need to know about the underlying science and technical jargon of your field. Speak slowly, spell each technical term, explain all technical terms, but also avoid their use as much as possible.

The triers of fact need to know if your opinions are derived from your education, your experience, or the literature. Concerning the latter, explain why you favor one study or approach, and also what contrary opinions exist and what concerns you have about them.

Admit to uncertainty. Explain if you are prone to give the benefit of the doubt in one direction, or else state what is more probable. (In legal terms, probability is a likelihood of 51% or better.)

Handling redirect

Examination in chief is followed by cross-examination. Should you be asked unfair questions that could create a misleading impression with the triers of fact, the counsel who called you can ask you a few follow-up clarifying questions during redirect, which follows cross-examination.

Listen very carefully to each question and answer as specifically as possible. Example: Q (in cross-examination): "Doctor, you wrote that my client might be engaging in malingered pretense. Isn't it a fact that you use this term in every medicolegal report you write?"

A: "Yes."
Q (in redirect): "Doctor, why do you use the term 'malingered pretense' in your reports?"

A: "Many of the claimants I see in IME develop chronic pain after minor accidents. Malingered pretense is part of the differential diagnosis. In my reports, I discuss the merits and limitations of each of the major diagnostic possibilities."

Caveats

The examiner must ascertain, as early as possible in a potential medicolegal consultation and/or IME assessment, whether one has a conflict of interest with the parties involved. These parties may include the insurance company, the workers' compensation payer, the lawyers, or the claimant (and family members). If there is a conflict of interest, then the most ethical thing to do at that point would be to offer to withdraw from participation in the case, with any further service subject to the consensus wishes of all concerned parties.

Most examiners, and particularly those certified through the American Board of Independent Medical Examiners, would argue that it is unethical to provide testimony regarding a specific claimant's impairments and disabilities if one has not had an opportunity to directly evaluate the individual in question. Obviously, there are circumstances in which a focused opinion about standard of care may be ethically provided without actually conducting an independent medical examination. Another example in which an exam may be a moot issue is in a wrongful-death case, where the claimant is obviously not available for examination.

Generally, one should avoid being directly critical of other professionals' work and/or qualifications, as related to the potential for slander and other negative legal ramifications. All comments, aside from testimony and opinions provided in the context of assessment of a malpractice issue, should be made in as constructive and non-pejorative a way as possible.

As possible, one should consider having a "hold harmless" clause in one's contractual agreement, relative to the opinions provided within the context of the IME report. Generally, at the end of the report, one should include a set of disclaimers, ensuring that one's potential liability is as fully covered as possible. An example of a template for such as a disclaimer is as follows:

> Any comments on appropriateness of care are professional opinions, based upon the specifics of the case, and should not be generalized nor necessarily be considered supportive or critical of the involved providers or disciplines. Any medical recommendations offered are provided as guidance and not as medical orders. I always request that the claimant's treating physician receive a copy of my IME report. I am also willing to discuss my opinions with the claimant's treating doctors, with permission from the retaining party. The opinions expressed do not constitute a recommendation that specific claims or administrative action be made or enforced.
>
> Medicine is both an art and a science, and although an individual may appear to be fit for work activity, there is no guarantee that the person will not be re-injured or suffer additional harm. If applicable, employers should

follow the processes established in appropriate formal documents such as the Americans with Disabilities Act, Title I. The opinions on work capacity are to facilitate job placement and do not necessarily reflect an in-depth, direct-threat analysis.

This independent medical evaluation is based upon the available history provided by the claimant during the IME of said date, and medical record review. This examiner's expertise as a —— [ie, board certified physiatrist, Fellow of the American Academy of Physical Medicine and Rehabilitation, etc] was also contributory to the opinions generated in this case. I am a physician duly licensed to practice medicine in the [state/province] of ——. All opinions are based upon a reasonable degree of medical probability, unless otherwise stated. If further information is required, please contact the undersigned.

The opinions rendered in this case are the opinions of this evaluator, based on his training, experience, and expertise in the field of [ie, physiatry (physical medicine and rehabilitation)]. Please refer to attached CV in Appendix 1. The conclusions of this report are based, in part, on the assumption that the materials provided for review are true and correct. I declare that the information contained within this document was prepared by this examiner and is true, to the best of my knowledge, at the time of issuance of this report. If more information becomes available at a later date, opinions are subject to change. I am being reimbursed on a fee-for-service basis, at the rate of $—/hr for my time in this case, as per my contractual agreement, which is also enclosed as an appendix.

There are significant debates about the potential downsides of having individuals other than the claimant present to observe the independent medical examination. Family members, lawyers, friends, or other third-party observers, such as a nurse case manager, may be among those expecting to be present. Many states have passed laws that prohibit the exclusion of such interested/invested parties from observing the IME process. In contrast, while in many jurisdictions there are no requirements or guidelines, in others the presence of observers is placed entirely at the discretion of the examiner, by judicial decision, or medical regulatory body guideline. The downside of the presence of such individuals is that it may alter the behavior of the claimant and/or the examiner in a manner that is counterproductive to the evaluation process [21].

In common with most independent medical examiners it is our belief that release of a draft version of an IME report for external review/feedback/revision by the referring party is not ethical. The examiner must scrupulously avoid even the appearance of compromised independence. If there are factual errors in the report, then a corrected copy can be submitted, with the original being kept on file. If there are updates with regard to information germane to the report and the examiner's opinions, a supplemental statement can be submitted.

As an examiner, it is important to be aware of the current guidelines and literature in the field of impairment and disability assessment, worker's

compensation, and social security disability determination, as these may be applicable to the evaluations that one is asked to perform [11,14,15,22].

Business aspects of the IME

No one particularly likes to discuss the business of IMEs. However, good business acumen promotes success in any physiatric practice. Being adept at the business end of medicine can be as important as being skilled in the clinical one, to ensure an efficiently stress-free provision of services.

Reasonable fees for physiatric medicolegal consultation probably range from $300 to $600 per hour, although there is clearly geographic variability in these charges. Charges should be fixed, based on the amount of time one spends on the process and not on different rates for specific activities. That is, there should not be different rates for reviewing records, evaluating the claimant, appearing for deposition, and going to court. Travel time should be billed at the same rate as any other time spent in a consultative context.

One should strongly consider having a contract for all consulting/IME work. The contract should stipulate the specific policy on charges for all aspects of work, including travel/waiting time, deposition time, and courtroom testimony. This should encompass any work outside of direct patient care. Generally, one is better protected, legally speaking, if there exists a contract signed by the party requesting the services, with the name of the claimant noted. The contract for a plaintiff IME should not be signed by the claimant but by the retaining party (ie, lawyer or work compensation carrier).

A retainer should be requested for a specified number of hours on all IMEs (eg, the first 3 to 5 hours). This retainer should be a minimum fee; however, money should be returned if it is not all used. The retainer is a measure of the good faith of the retaining party, and it guarantees minimal payment for that amount of time, as IME clinicians have occasionally been "stiffed" on their bills, even with good contracts in hand.

Invoices should be billed on at least a 30- to 45-day cycle, and contractual stipulations should specify late charges if bills are not paid within a reasonable time after receipt. It is important to stipulate cancellation polices in the context of IMEs, as well as deposition and courtroom testimony, in the agreement letter and/or contract. One might consider having an administrative fee for staff time spent organizing the chart, coordinating depositions, and requesting and copying records, among other activities. Fees for independent medical examination work should never be discounted for high-volume users and certainly should never be set on a contingency basis.

If there are problems getting paid, a staff member should call to inquire about the status of overdue bills. After three calls by staff and no payment, the examiner should call and talk directly with the party responsible for requesting the examiner's involvement, or his/her supervisor. Failing that, a letter should be written to state that no payment on the account has been received and that the account will be turned over to a collection attorney, as

necessary. The retention letter and contract should be enclosed, and the letter should note that a copy is being sent to the examiner's attorney. If the retaining party is an attorney and no payment has been received after the aforementioned efforts have been made, a follow-up letter should state that the attorney will be reported to the state bar association for default on the agreement. This potential "black mark" generally prompts expedient payment. In lieu of sending the letter to the state bar association, a lawsuit may be filed, to recoup damages and unpaid debt. There is also the option of declaring the uncollected money as a business loss. (In most cases, it is more cost- and time-efficient to take the loss.)

Qualifications

The best IME clinicians are made through working in the trenches, not just by having multiple letters (certifications) after their name. Nonetheless, examiners who are well qualified based on training and certification probably are in a better position to acquire referrals than those who do not have extensive training and certification in the area of impairment and disability evaluation.

Training opportunities abound now in the area of disability evaluation, as well as impairment rating. There are numerous organizations in the United States and Canada as well as internationally that address the training needs of impairment and disability evaluators. Many of these organizations are relatively "lightweight," in terms of the requirements to become certified. Others, such as the American Board of Independent Medical Examiners, the American Academy of Disability Evaluating Physicians, and the Canadian Society of Medical Evaluation have more stringent criteria for membership and certification. As one attends training courses, it definitely becomes apparent that there is an art, as well as a science, to performing independent medical examinations. Much of the knowledge garnered in these types of training programs will be about the nuances of impairment and disability assessment, as well as various medicolegal components that are inherent in performing "bulletproof" IMEs. Certainly, as training can be provided in the context of continuing medical education (CME), this is preferable; however, not all of the courses being offered necessarily have CME accreditation.

Conclusion

IMEs can provide a skilled practitioner with an intellectually stimulating change of pace from the traditional activities of medicine, as well as, potentially, a reprieve from the limitations of "managed care" reimbursement. To adequately pursue IMEs, clinicians must understand the nuances associated with the medicolegal, ethical, and business aspects of such an endeavor. Knowing one's strengths and limitations as a practitioner is

paramount to good IME practice. Most importantly, the pursuit of truth, in the context of ethical practice, clinical thoroughness, and medicolegal neutrality, must prevail when performing IMEs.

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