

INDEPENDENT EXAMINER



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Abstract

In a prior article (Haberströh & Mulhern, 2005), we explained how field practitioners can better document case files to withstand challenges, including those made by independent examiners (IEs). The article also addressed the forensic examination of IEs. In this article, we seek to establish reasonable standards to which IEs should be held. In this way, examiners' credibility can be established. Currently, the unfortunate reality is that in the vast majority of jurisdictions in the United States any doctor can become an IE simply by requesting a job from an IE company or intermediary; for most states, there are simply no standards, no good guidelines, and no certification processes. We find this unacceptable. It has become the norm, not the exception, that IEs hold field practitioners up to lofty standards that few, including the IEs themselves, can reach. Thus, bills are cut, complaints are sometimes filed with boards, and other professionally aggravating and costly situations arise from untrained supplicants who exceed their mandates of case review.

Key Words: independent examiner (IE), peer review, forensic exam, report magnification, behavioral signs, junk science



Introduction

This paper suggests reasonable standards that should be met by all independent examiners (IEs) of any health care discipline. This includes qualifications in education, field experience, and post-graduate training. We discuss paradigms for the IE once he or she is actually performing reviews and/or examinations on patients. To date, solid, fundamental paradigms have never been established for IEs, and this paper seeks to ameliorate that deficit. It should be noted that this article was written by chiropractors and focuses more on chiropractic practices than other fields.

Basic Qualifications for the Independent Examiner

The practitioner performing independent examinations must meet a high set of standards. Everyday field practitioners are held to these same standards, and we see no valid reason why IEs should not be also. We, after years of experience dealing with IEs, strongly urge the following as basic qualifications:

- 1.) The IE should have a valid license in the examining jurisdiction.
- 2.) The IE should have a minimum of 3 years experience practicing in the field as an associate doctor or in solo/group practice. We feel this is consistent with the latest board requirements in Massachusetts regarding registering one's practice with the board. The length of time could be longer or shorter, but the authors feel that 3 years is a fair and reasonable amount of time for a new graduate to have begun appreciating the general aspects of a practice.
- 3.) The IE should have certification in independent reviewing, including patient examining and paper reviewing. Chiropractic colleges have sponsored occasional courses for certification in independent examining and peer review. Usually, the certification is good in any jurisdiction. The problem is that few requirements exist for this type of certification in the United

States except in Mississippi, Missouri, Kentucky, and Texas. State societies or medical/chiropractic schools could change this by offering qualified courses that doctors could earn credits for taking.

4.) The IE should have at least 12 hours per year of continuing education specific to independent examining and/or peer reviewing.

5.) The IE should maintain an active practice, using at least half of his or her time to see patients. This qualification could be waived for retired doctors who have passed a recognized certification course in independent reviewing.

6.) The IE should be compelled to reveal who has requested the exam/report if asked. We include this seemingly odd point for the simple reason that there are many fourth-party interlocutors who are contacted by insurance companies for independent examinations. A fourth party will farm out the business to hired IEs who say they have no relationship at all with the insurance company and are thus truly independent. We feel this fiction is one of the more oxymoronic aspects of independent examinations and should be relegated to a more open "truth-in-trade" assignment.

7.) The IE should have an accurate, up-to-date CV available at all times to anyone who asks for it in a timely manner.

8.) All jurisdictions should acknowledge and inject language into their rules and regulations that a patient/doctor relationship exists between the IE/peer reviewer and the patient.

We feel that because the IE industry is completely unregulated, guidelines should be instituted. The afore-mentioned requirements represent merely a basic, fundamental set of suggested parameters for a doctor considering going into the IE business and for the boards who issue licenses and are supposed to protect the public trust. The purpose of independent examinations is for the review of the propriety or necessity of a given treatment for a particular health condition for a particular patient. This is most often done at the behest of a third-party payer such as an insurance company. The insurance company, therefore, has a fiduciary duty to the subscriber to pay for what is considered reasonable and necessary treatment. The IE is, then, an agent for the insurance company, and thus has

no responsibility to the patient/subscriber in any way, shape, or form. Obviously, although there is a set fee paid to the IE for each report he or she writes, future work is more likely if the insurance company is satisfied with the IE. For example, if the IE recommends discontinuation of treatment, the insurer will save money. Thus, there is an obvious financial incentive for the IE agent to undercut treatment protocols and disallow treatment and reimbursement for the provider who has rendered care.

The insurer has a blind trust that the exams and reports submitted by the IE are truthful and accurate. The only ethical standards are those within the individual IE. No statutory regulations regulate IEs in the vast majority of jurisdictions that we have researched. Thus, the IEs can, and many do, serve their own financial needs with their reports and conclusions.

This system is ripe for abuse. There are no consequences that we can find for the IE no matter what he or she says or does, which becomes especially apparent in defense evaluations such as when a case is litigated. We find this totally unacceptable. Again, this situation not only invites abuse but also encourages it. The goal of any examination, forensic or otherwise, is truth, and the truth cannot be ascertained without thoroughness. IEs are supposed to follow the evidence. The problem in the chiropractic/medical arena is that some of the evidence is subjective on the part of the patient. That type of evidence often consists of the patient's reaction to a provocative orthopedic or neurologic test in the clinical setting that can be colored by ethnic background (as in a standard ethnic reaction to touch and/or pressure; see discussion of Waddell's signs), the degree or level of aggravation of the pathology on the day of the exam, and so forth.

The treating doctor's goal is the health and welfare of the patient. Thus, the ethical core principle of all doctors, that of *primum non nocere* (the first thing is to do no harm), often isn't compatible with the testimony or report writing of an IE, which can lead to harmful outcomes such as denial of care and/or monetary loss. Later in this paper, we'll discuss further refinements of these parameters and make further suggestions on how to bring the archaic IE system up to standards.

Chiropractic Board Rules and Regulations

In an effort to be thorough and objective about our statements and conclusions, the authors have researched all available chiropractic board websites. (We did not examine medical or physical therapy websites or board rules/regulations.) Luckily, the National Board of Chiropractic Examiners' website serves as a master website that provides links to all of the chiropractic state boards (<http://www.nbce.org>). For ease of understanding and to decrease clutter in the body of the text of this article, we simply refer to each state board website by the state name only.

At the time this article was written, the National Board of Chiropractic Examiners' website indicated that four states did not have a website for their state chiropractic board: Kentucky, Mississippi, Missouri, and New Hampshire. Yet, our investigation revealed that New Hampshire is the only state without a website of any kind, that Mississippi and Missouri have websites, and that Kentucky started its website while this article was being written. Most other states don't have a dedicated chiropractic website. Rather, most of the state board websites are more akin to a web address that leads the researcher to a general state government home page and from there to a state government website that has rules and regulations for chiropractors.

A few states, such as Massachusetts, do have well-constructed, well-thought-out, dedicated websites for everyone to access, despite being part of a broader state government online system. Additionally, some states, such as Massachusetts, don't have statutory regulations for peer-reviewer/IE exams but do have board policies on this issue. These policies have no legal bite and are merely suggested guidelines. We've made an effort to thoroughly review statutes and general policies to ascertain whether a given state has made any kind of attempt at regulating peer reviews and/or independent examinations.

Policies, Rules, and Regulations Regarding Peer Reviewers and/or IEs by State

We refer to states that have more dedicated, well-constructed websites as W-sites, states that have a more generic tab listing for chiropractic issues as W-tabs, and those with-

out Internet links as "no web link." We occasionally comment on the sites themselves and their ease of navigation and, of course, comment on whether relevant IE/peer reviewer rules, regulations, or policies exist.

1.) **Alabama:** W-site; has no peer-reviewer/IE policies or regulations.

2.) **Alaska:** W-site; has an in-house board-controlled peer-review committee but no actual peer-reviewer/IE policies or regulations are listed.

3.) **Arizona:** W-site; has no peer-reviewer/IE policies or regulations.

4.) **Arkansas:** W-site; has no peer-reviewer/IE policies or regulations.

5.) **California:** W-site; has no peer-reviewer/IE policies or regulations.

6.) **Colorado:** W-site; has a utilization review policy that flatly states that every utilization review doctor is held to the same standards as a practicing DC. Otherwise, the site does not delineate peer-reviewer/IE policies or regulations.

7.) **Connecticut:** W-tab; is a generic state government site that is extremely difficult to navigate. Repeated attempts to search for "chiropractic board," "board of chiropractic examiners," "chiropractic examining board," etc., resulted in no direct connection. Apparently, the state has a board of chiropractic examiners listed somewhere in the state site, but we were unable to locate it.

8.) **Delaware:** W-tab; has no peer-reviewer/IE policies or regulations.

9.) **District of Columbia:** W-tab; is a general government website yet was simple and easy to navigate. The site listed no peer-reviewer/IE policies or regulations.

10.) **Florida:** W-tab; has no peer-reviewer/IE policies or regulations.

11.) **Georgia:** W-site; has no peer-reviewer/IE policies or regulations.

12.) **Hawaii:** W-tab; has no peer-reviewer/IE policies or regulations.

13.) **Idaho:** W-tab; has a peer-review committee. According to statute, the board members themselves or DCs appointed by the board may serve on the peer-review committee. No actual rules or regulations delineate how the DCs can function. We assume that the peer-review committee adjudicates files according to standard rules and regulations.

14.) **Illinois:** W-tab; has no peer-reviewer/IE policies or regulations.

15.) **Indiana:** W-site; has no peer-reviewer/IE policies or regulations.

16.) **Iowa:** W-tab; has a peer-review committee made up of DCs appointed by the board to investigate complaints. No actual peer-reviewer/IE policies or regulations exist that we can find.

17.) **Kansas:** W-site; has the Kansas State Board of Healing Arts. Many medical professionals fall under one huge board that governs them all. The board members consist of a group of MDs, DCs, and DOs. There are no specific peer-reviewer/IE policies or regulations.

18.) **Kentucky:** W-site; has a progressive peer-review policy along with a definitive procedure to become a peer-review doctor. Despite the information on the National Board of Chiropractic Examiners' website stating that Kentucky does not have a website, we learned that Kentucky went online on October 27, 2005. After calling the Kentucky Board of Chiropractic Examiners, the board developed a website, and we were pleasantly surprised with their policies. The peer-review rules are statutory (Ky. Rev. Stat. Ann. § 312.200) and include the provisions that the board shall approve of a peer-review committee that cannot have ties to insurance companies and that must have completed an annually approved utilization review course. Furthermore, the doctors doing peer review must register with the board and pay a fee.

19.) **Louisiana:** W-site; has a peer-review committee. This committee reviews, on any request, any matter relative to the appropriateness of care rendered by any DC. A fee is paid directly to the board, and the committee renders a judgment. Currently, the peer-review committee only has one board member. Parties can approach the peer-review committee as stated, or doctors throughout the state can perform peer reviews and independent examinations outside of the official peer-review committee. Nowhere did we find actual peer-reviewer/IE policies or regulations. The board committee simply reviews files based on, we presume, board rules and regulations and their own sensibilities as to what constitutes over-utilization, unprofessional conduct, etc.

20.) **Maine:** W-tab; has no peer-reviewer/IE policies or regulations.

21.) **Maryland:** W-site; has no peer-reviewer/IE policies or regulations.

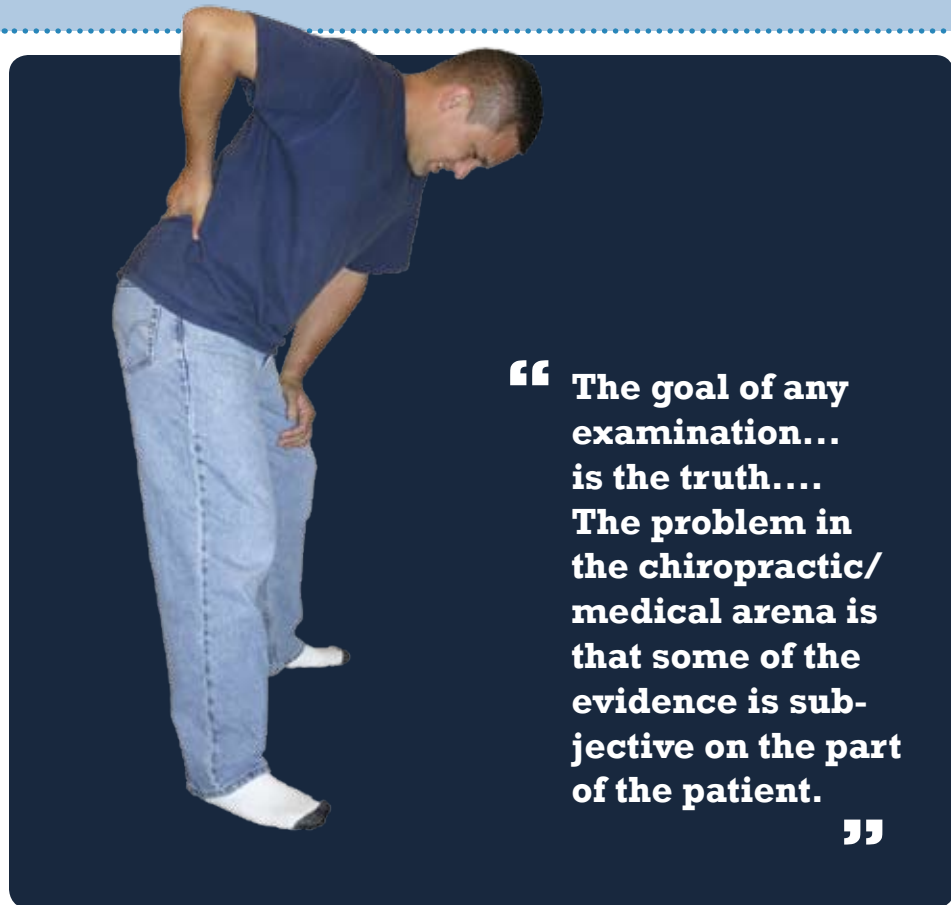
22.) **Massachusetts:** W-site; has peer-review guidelines. These, like all policies promulgated by various boards, are akin to mere suggestions. They carry no legal weight, which is stated in the disclaimer at the beginning of the guidelines. No IE rules or regulations exist.

23.) **Michigan:** W-tab; has no peer-reviewer/IE policies or regulations. We found the secretary of state's website excessively difficult to navigate.

24.) **Minnesota:** W-site; has a board regulation regarding IEs. They even call them independent examiners. In this case, the doctor has to prove he or she is registered with the state board, has to prove he or she has been in practice or has been an instructor for at least 2 years, and has to devote at least 50% of his or her practice to treating clinical patients.

25.) **Mississippi:** W-site; has regulations regarding reviewers that state that the DC who performs examinations must have taken a 300-hour course of study in chiropractic claims reviews (Miss. Code Ann. § 73-6-17). Unfortunately, none of this information is available on the National Board of Chiropractic Examiners' website.

26.) **Missouri:** W-site; has regulations regarding reviewers. Missouri appears to have one of the most organized and thorough approaches to IE examinations. The Missouri Code of Regulations (Mo. Code Regs. tit.4, § 70-4.010) states that a.) the DC must be certified as an insurance consultant, b.) the DC who reviews must notify the board that he or she is engaged in this activity and must report the correct address at which he or she is doing this consulting, and c.) no DC may receive compensation from a third-party payer based in whole or in part on the amount of fee the licensee recommends be reduced or denied when the licensee is reviewing files of persons other than his or her patients for the purpose of determining the adequacy or sufficiency of chiropractic treatments. The exact meaning of this last statement was unclear until we called the Missouri Board; Provision (c.) was designed to prevent DCs from purposely cutting bills so insurers would be more inclined to send



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them business. The National Board of Chiropractic Examiners erroneously states on its website that Missouri's board does not have a website.

27.) **Montana:** W-tab; has no peer-reviewer/IE policies or regulations.

28.) **Nebraska:** W-tab; has no peer-reviewer/IE policies or regulations.

29.) **Nevada:** W-site; has no peer-reviewer/IE policies or regulations. Interestingly, this is the only website to offer multiple language options. Even more impressive is the wide variety of languages offered.

30.) **New Hampshire:** No web link. A call to the state board of examiners confirmed that they have no peer-reviewer/IE policies or regulations.

31.) **New Jersey:** W-tab; has peer-reviewer/IE regulations. They are brief and simply state that the examining doctor performs these exams at state standards. Although not too stringent, these are at least statutory regulations that clearly state that examinations are to be thorough like those performed by any practicing doctor.

32.) **New Mexico:** W-tab; has no peer-reviewer/IE policies or regulations.

33.) **New York:** W-tab; has no peer-reviewer/IE policies or regulations.

34.) **North Carolina:** W-site; has no peer-reviewer/IE policies or regulations.

35.) **North Dakota:** W-tab; has no peer-reviewer/IE policies or regulations.

36.) **Ohio:** W-site; has no peer-reviewer/IE policies or regulations.

37.) **Oklahoma:** W-site; has no peer-reviewer/IE policies or regulations.

38.) **Oregon:** W-site; users will have to navigate to this site, but it is fairly comprehensive and well organized. Oregon actually has a peer-review law that is listed separately under "Rules & Regs" as well as under "General Rules & Licensing" (Or. Admin. R. 811-010-0095). The latter basically rehashes the chiropractic rules and regulations because peer-review committee members are appointed by the board and, as such, are agents of the board. Peer-review committee members review on request by any party the appropriateness of care under the rules and regulations of Oregon. Interestingly, the peer-review committee does not replace independent medical examinations (IMEs). Nowhere do any of these rules, regulations, or statutory laws address IMEs. Additionally, no actual policies or specific laws govern peer reviewers other than stating that they are to be DCs

in good standing who have been in practice for more than 5 years.

39.) **Pennsylvania:** W-tab; has no peer-reviewer/IE policies or regulations.

40.) **Rhode Island:** W-tab; has no peer-reviewer/IE policies or regulations.

41.) **South Carolina:** W-tab; has no peer-reviewer/IE policies or regulations.

42.) **South Dakota:** W-site; has peer-review policy. This site is simple but well organized. To quote the mission statement, "The Board of Examiners may act as a peer-review committee or appoint other board chiropractors to perform the duty." This situation is similar to all other board-sanctioned peer-review committees in that it is a subjective examination occurring in response to a submitted request for review as per state board rules and regulations. The only twist here is that patient-requested peer reviews have no charge. For all other requests, \$300 payable to the board is required. Again, no special rules, regulations, or statutes address peer reviewers or IEs.

43.) **Tennessee:** W-tab; has no peer-reviewer/IE policies or regulations. Interestingly, this state has a peer-assistance policy. This policy has nothing to do with our research or this article, but we found it so interesting that we felt a brief comment was warranted. The peer-assistance policy is for DCs who may be impaired for some reason, whether physically, pharmacologically, mentally, etc. It is designed to offer needed help and resources to those professionals who need it. Tennessee is the only state board to have such a policy.

44.) **Texas:** W-site; has peer-review statutes pursuant to the Texas Chiropractic Act (Tex. Occ. Code § 201.251-55). We found this law to be fair and at times truly enlightened and a good model for other states. To briefly summarize, the board of examiners appoints local chiropractors, presumably through local state societies, to be on local peer-review committees. Thus, the state is replete with local committees covering all geographic areas. Only DCs who have completed a program of peer-review training approved by the board are eligible to serve on these local peer-review committees. The DC cannot be a consultant or an employee/agent of any company or carrier of health care insurance. The

board establishes requirements for peer-review training programs. The board also appoints an executive chiropractic peer-review committee to direct the activities of the local committees. The executive peer-review committee conducts hearings relating to disputes referred by the local peer-review committees and makes recommendations based on the evidence. The executive committee also cannot be affiliated in any way with insurance companies. We find the clauses regarding non-connection with insurance companies and appointing local sub-committees truly inspired thinking.

45.) **Utah:** W-tab; has no peer-reviewer/IE policies or regulations.

46.) **Vermont:** W-tab; has no peer-reviewer/IE policies or regulations.

47.) **Virginia:** W-tab; has no peer-reviewer/IE policies or regulations. This board is officially designated as a board of medicine. The chiropractic board is mixed in with the medical board, and the chiropractic rules and regulations are blended in with their medical analogs.

48.) **Washington:** W-tab; has no peer-reviewer/IE policies or regulations. Interestingly, this board is not called a board but rather the Chiropractic Quality Assurance Commission. The website is difficult to navigate, and chiropractic issues are blended into an admixture of all health professionals, with one large set of rules and regulations.

49.) **West Virginia:** W-site; has no peer-reviewer/IE policies or regulations. This dedicated website is very simple to navigate and understand. There is not much to this site, which is why it is so easy to navigate.

50.) **Wisconsin:** W-tab; has no peer-reviewer/IE policies or regulations. The site is a very generic sub-tab that has to be navigated to indirectly from the state government site. The rules and regulations for chiropractors are interspersed with those for other professionals such as accountants.

51.) **Wyoming:** W-tab; has no peer-reviewer/IE policies or regulations. Navigating to this site is an ordeal. Trying to find the actual rules and regulations can be even more of a time-consuming exercise.

Paradigms for the Independent Examiner

In an effort to improve the current IE situ-

ation, we pose seven paradigms and recommendations for each.

Paradigm #1. We have patients who have been independently examined throughout the years. Each patient fills out an affidavit, after the fact, describing his or her encounter with the IE. Nearly universal in their responses, these patients indicate that the "exams" they underwent were usually 3-8 minutes long. The question that begs to be asked, therefore, is whether IEs should be held up to the same standards as a field practitioner. We say yes, they should.

We feel strongly about the actual mechanisms of an independent review. In the 20-plus years that IEs have been in vogue, we have seldom seen examinations that rise to a statutory standard-of-care type of exam. Field practitioners are, by statute, required to take a detailed case history, obtain vitals, conduct relevant orthopedic and neurological testing to include the cranial nerves as well as provide a DDX (differential diagnosis), a DX (diagnosis), and a plan of treatment for the future. We feel, therefore, that it is unfair and simply unprofessional to allow IEs to get away with brief, nearly ad hoc exams that seldom include even basic vital signs. It is rare that IEs will take a blood pressure, let alone perform competent neurological exams (Bates, Bickley, & Hoekelman, 1995; Foreman & Croft, 2001).

Paradigm Recommendation #1. IEs must be compelled to do thorough examinations.

We further recommend that if the doctor feels he or she is lacking information, such as aspects of the case file, x-rays, hospital records, etc., he or she should indicate so and avoid conclusions based on too little data.

IEs should acknowledge what they consider lacking in a review. Whether they are doing an exam or just a peer review, any data the examiners feel would enhance their knowledge of the case should be stated, and their conclusions should be labeled as tentative, pending further data acquisition.

Paradigm #2. Some IEs do not like witnesses, an unfortunate prejudicial oddity. We're not sure why this is so. Often, an

IE will allow one witness, sometimes two. We feel that to help avoid conflicts after the fact, it is good to have a witness who can corroborate the encounter, especially for those occasions in which language barriers exist.

Paradigm Recommendation #2. IEs should allow up to two witnesses to attend an exam. That is to say, the examinee should decide who and how many witnesses attend the independent examination. We are not aware of any statute or guideline that addresses this issue to any degree. Currently, at least in Massachusetts, custom allows the IE to decide how many witnesses will be present, which makes no sense at all, but no regulation or even a guideline states this. We see no reason not to allow witnesses except in the very rare case in which physical space may be lacking. Naturally, the witnesses are admonished to remain silent during the exam. We recommend that audio and/or videotaping be allowed by the patient or his or her witnesses for the purpose of recording the encounter accurately. We see only advantages to these suggestions: a) witnesses and/or a videotape of the event will provide a more detailed and accurate history of the encounter should discrepancies arise later as to what really happened; b) taping will discourage report magnification by the IEs because after the current standard 3- to 5-minute exam, IEs typically write a 9- to 12-page report listing a myriad of clinical tests that may not have been performed; and c) the presence of a bilingual witness can obviously allow an exam to move forward in the event of a language barrier without the witness.

In our research, we found several references that address the issue of witnesses, but all of them focus nearly exclusively on mental health professionals who were witnesses themselves in the trial and pre-trial arenas. Melton, Petrila, Poythress, and Slobogin (1997) delved into interesting areas such as witnesses exaggerating their résumés, expert witness testimony in various legal situations, and strategies during cross-examination. The bulk of the book spoke from a forensic psychologist's point of view, discussing the role of the psychologist as a witness.

According to Gutheil (2002), a fact witness may testify in court only on what was

directly observed by his or her five senses; an expert witness on the other hand, has the latitude by the court to actually draw conclusions from the available data. The expert can even draw conclusions from data not personally observed by the witness. Appelbaum (1990) has pointed out that the traditional doctor-patient relationship does not apply between the forensic examiner and the examinee (patient). In any event, when we speak of a witness, we speak of an individual who merely observes an IE encounter, not an expert witness. It is our opinion that a fact witness will not adversely affect the independent examination and most likely will enhance the encounter with a factual recitation of the dispositive actions taken during the encounter.

We acknowledge that an independent examination is a forensic examination on behalf of a third party, but we hasten to add that we believe that a relationship does exist, however brief, between the IE and the patient. This is no longer conjecture. Recent literature (Bates, Bickley, & Hoekelman, 1995) and court rulings (Council on Ethical and Judicial Affairs, Opinion 10.03, 2004; *Dugan v. Mobile Medical Testing Services, Inc.*, 2003; Mass. Gen. Laws ch. 112, 2005; National Board of Chiropractic Examiners, n.d.; *Reed v. Bojarski*, 2001) have clarified and removed all doubt in this argument. There is a limited patient-doctor relationship between the IE/peer reviewer and the patient. A professional *syzygy* exists as a matter of law. This obviates the disclaimer still used by some IEs that a relationship does not exist. (See also the information about the AMA Council on Ethical and Judicial Affairs later in this article.)

Paradigm #3. Waddell signs, or behavioral signs, as we discussed previously (Haberströh & Mulhern, 2005), have no place in independent examinations, yet IEs continue to use them to disallow treatment and cut off care. We pointed out that according to Dr. Waddell himself, there are three major caveats to the use of the behavioral signs: 1) patients with serious spinal pathology should not be tested because the results are meaningless; 2) ethnic minorities should not be tested for the same reasons; and 3) patients more than 60 years of age should not be tested.

Paradigm Recommendation #3. The behavioral signs, or Waddell signs, should not be used by the IEs. State boards need to revamp board regulations to disallow the use of these signs as a means to cut off care. Other than screening for pre-surgical candidates, they serve no purpose.

Paradigm #4. Field practitioners have no recourse other than a lawsuit when an IE cuts off patient care, assuming the care was reasonable and necessary in the first place.

Paradigm Recommendation #4. We urge either state legislatures or the boards themselves to set up independent oversight committees in concert with state societies. This is somewhat similar to what Texas is doing already. These committees should consist of field practitioners rather than members of the state board and should be granted the authority to hear complaints by treating doctors who believe unreasonable IE reports and decisions were rendered against them. The committees should have at least three members review each complaint and should examine the patient records (redacted, of course) and the IE report. The committees should then render a binding decision as to the merits (or lack thereof) of a given complaint and resolve the dispute in a fair and balanced way. In this manner, field practitioners would have an outlet to voice grievances. Ideally, the committees' decisions would be binding, authoritative remedies one way or the other in disputes of this nature. This procedure has the added benefit of lending credibility to a field doctor's rebuttal of an unfair IE's report. As it stands now, most insurance adjusters automatically conform to what the IE says. Rebuttals are ignored by the adjuster and merely forwarded to the IE who, if he/she bothers responding to the rebuttal at all, most often simply says his/her opinion remains unchanged. Thus, the IE's opinion prevails regardless of any factual, substantive opinions to the contrary.

Corollaries to Paradigm #4.

1.) Having board members who do independent examinations and peer reviews without an independent system of adjudication is oxymoronic. In Massachusetts, for example, at least one board member is a well-known peer reviewer. Complaints

come to the board against this individual, but the complaints are summarily and routinely dismissed. Failing to thoroughly examine the complaints in no way protects the public, which is the alleged mandate of this board and all boards (Gutheil, 2002).

2.) IEs and peer reviewers should be statutorily liable for damages in the event the care they may cut off was actually needed and the unfortunate patient suffered because of the premature termination of care by the contracting examining doctor. We feel this goes back to the issue of whether a patient-doctor relationship exists and/or an encounter with the patient and a one-time independent examination has occurred or even a one-time review of the patient's file took place (Appelbaum, 1990). Now that this argument has been clarified and we know a relationship exists between the IE and the patient, we feel the independent doctor should be held to the same standards and liabilities as the treating doctor. Several courts have recently declared that IEs are liable. In 2004 the Michigan Supreme Court held that a physician who conducts an IME for personal injury litigation creates a limited physician-patient relationship and, therefore, may be liable for physical harm caused to the patient during the examination (*Dyer v. Trachtman*). Also in 2004 the Arizona Supreme Court decided that a radiologist interpreting chest films for possible tuberculosis screening for an employer may be liable for failing to take reasonable steps to inform the patient of other unrelated findings suggestive of other potentially life-threatening conditions (*Stanley v. McCarver*). The high courts in several other states, including Colorado, Connecticut, Montana, and New Jersey, have all addressed the issue of physician liability in IMEs and all have recognized the potential for liability in certain situations (Baum, 2005). The question is no longer whether a patient can sue an IE but how much liability the IE/peer reviewer is exposed to. That discussion exceeds the scope of this article but is well worth exploration.

Paradigm #5. Predicting the outcome of a case is folly for a non-treating physician. We believe that the regular practice of predicting a timeline based on a single exam or the mere reading of the case file

(peer review) is akin to fortune telling and has no place in modern health care practices or independent examinations and is another example of junk science. Clearly the best prognosticator is the treating physician (Baum, 2005). The well-traveled, credentialed professional's recommendations should have much more weight in a discussion of prognosis than those of an IE who has only had one visit with a patient.

Paradigm Recommendation #5. Cases that are pre-ordained to be cut off by a one-time IE's exam or paper review are ludicrous. Our recommendation is that IEs be prohibited from making such predictions by their state boards. They are to examine the patient or the file and render an opinion but not state that the patient will be fine in a certain amount of time or number of visits. It is junk science to state the always popular but unfounded and unsupported opinion that, for example, a car accident soft-tissue-injury victim will recover in 8 weeks no matter what therapy is or is not used (Foreman & Croft, 2001).

Paradigm #6. Randomness exists in independent examinations because they are carried out at any time during a patient's treatment regime. We feel this is unfair to the patients and the practitioners. Too often, a patient must undergo an independent examination after only a few visits with the treating doctor. In similar cases, the independent examination is performed at or near the end of treatment. In some instances, the independent examination is performed long after care has stopped and the patient has been discharged. We again find that there is no method to this kind of random examining. It is a strictly "make it up as you go" approach to patient treatment decisions, especially when an exam is performed after treatment has stopped and the IE has recommended retroactively cutting care and, hence, the treating doctor's bill.

Paradigm Recommendation #6. We strongly urge state boards, possibly in conjunction with the state societies, to set up stringent guidelines as to when an independent examination can be performed on a patient who is currently undergoing treatment. We suggest further that the in-



dependent examination be set up in the middle of treatment with all other paradigm suggestions to be followed. The idea that an IE can retroactively disassociate the patient and his or her treatment, and furthermore suggest that because the patient has no findings or that there must have been minimal to no injuries, is nothing short of ludicrous.

Paradigm #7. The new trend in 2005 was for some IEs to download quotes out of context. The dumping of junk science into a report and forwarding the report as an erudite treatise on a patient's medical status is unprofessional (Freeman, 2005).

Paradigm Recommendation #7. We advocate a ban on the use of junk science in report writing by any doctor in any situation. We find it appalling that data can be stated, taken out of context, twisted, and/or utterly convoluted so that the text is manipulated differently from its original intent. Our discontent is not limited to these reports but extends to CVs that doctors embellish (Melton et al., 1997). This kind of sophism also has no place in the chiropractic/medical/legal world and often leads to report magnification.

Summary of Recommendations

1.) Doctors embarking on full- or part-time careers as IEs/peer reviewers should stop, think, and make informed decisions. They need to understand that by conduct-

ing independent examinations/peer reviews, they enter into a physician-patient relationship in the eyes of the law. This may include the responsibility to diagnose a patient and, thus, their liability increases markedly.

2.) Clear documentation helps all doctors. The IE needs to eliminate confusion on the part of the patient and clearly state that a doctor-patient relationship exists but that a third-party initiated the examination. A witness who accurately records the events and an IE who performs a thorough exam will help to make the experience more professional and reduce liability issues later. We urge recording on videotape.

3.) If certain important conditions are discovered during an independent examination, the IE should inform the patient. Additionally, the IE should make sure the patient understands that he or she is not the primary doctor and that the patient should follow up with his or her personal care provider, personal physician, and/or DC at the earliest possible moment. This should be highly and meticulously documented.

4.) Finally, the IE should understand that, just as with a regular field practitioner, good documentation and open communication with the patient might not be enough to shield the IE from future malpractice actions.

Conclusion

As of this writing, the United States has few standards that govern chiropractic peer reviews and/or independent examinations. Some states, including Minnesota, Missouri, Mississippi, and Kentucky, stood out in our investigation as having well-thought-out and reasonable regulatory and/or statutory criteria that, for example, actually require peer-review credentialing before performance of the peer review and verification that no affiliation exists with any insurance company. Texas' system was the best model in our opinion because of its additional program of using numerous statewide sub-committees for IE adjudication. Without a policy similar to the one in Texas, medical and chiropractic IE testing has no methodology, no standard of practice, no checks and balances, no credentialing, and no logical formatting. We know this from the thousands of independent examinations performed on chiropractic patients by medical IEs each year. As we stated in our previous article on this subject, the orthopedic doctors are usually fairer and far more reasonable in their conclusions. Nevertheless, regulatory statutes can only raise the standard for all IEs and better serve the patients the IEs examine.

In addition, the only way to challenge IEs is to drag them into court, which is time-consuming and expensive for all. IE testing has been in vogue now for about 20 years, but in most jurisdictions it is still completely random in all of its inventories. We consider this to be unacceptable and believe we speak for the majority of field practitioners when we say this. Furthermore, independent examinations need to be regulated. We do not suggest that IEs be abolished, but rather, we advocate the establishment of standards of care for this aspect of patient-doctor interaction, as in all other aspects of the patient-doctor relationship. It is the one area remaining that has never been regulated. Left to its own devices, independent examining has become a random miasma of occasionally unprofessional caprice by the IE companies that hire these doctors and the doctors themselves. We feel that this impromptu approach to patient-doctor interaction is completely unacceptable and dangerous to the patients. This type of makeshift practice would never be tolerated with a field

practitioner. Why allow IEs to practice this way?

Also, we must state again that independent examinations/peer reviews establish a patient-doctor relationship. The American Medical Association agrees, stating in its Code of Medical Ethics that "when a physician is responsible for performing an isolated assessment of an individual's health or disability for an employer, business, or insurer, a limited patient-physician relationship should be considered to exist" (Council on Ethical and Judicial Affairs, 2004). Addressing this issue in this article is a small first step in reigning in a completely unregulated aspect of health care that is literally out of control and, in our opinion, dangerous to the public. We urge state boards and the state societies, especially in the chiropractic arena, to redress this important issue.

References

- Appelbaum, P. S. (1990). The parable of the forensic psychologist: Ethics and the problem of doing harm. *International Journal of Law and Psychiatry*, 13(4), 249-259.
- Bates, B., Bickley, L., & Hoekelman, R. (1995). *A guide to physical examination and history taking* (6th ed.). Baltimore: J. B. Lippincott Co.
- Baum, K. (2005, June). Independent medical examinations: An expanding source of physician liability. *Annals of Internal Medicine*, 142(12).
- Council on Ethical and Judicial Affairs, American Medical Association. (2004). *Code of medical ethics: Current opinions, opinion 10.03, patient-physician relationship in the context of work-related and independent medical examinations*. (pp. 303-4). Chicago: AMA.
- Dugan v. Mobile Medical Testing Services, Inc., 830 A.2d 752 (Conn. 2003).
- Dyer v. Trachtman, 679 N.W. 2d 311 (Mich. 2004).
- Foreman, S., & Croft, A. (2001). *Whiplash injuries: The cervical acceleration/deceleration syndrome* (3rd ed.). Baltimore: Lippincott, Williams, & Wilkins.
- Freeman, M. (2005). *Junk science by IME doctors*. Retrieved from <http://doctorwhiplash.com/ACR/frames/Junk%20Science%20by%20IME%20Doctors%20-%20Freeman.htm>
- Gutheil, T. G. (2002). The psychiatric expert witness. *Psychiatric Times*, 19(4).
- Haberströh, John J., & Mulhern, K. (2005). Properly documenting a file and forensic examination of IME doctors. *The Forensic Examiner*, 14(4), 26-39.
- Ky. Rev. Stat. Ann. § 312.200 (Thomson/West 2005).
- Martinez v. Lewis, 969 P.2d 213 (Colo. 1998).
- Mass. Gen. Laws ch. 13 (2005).

Mass. Gen. Laws ch. 112 (2005).

Melton, G. B., Petrila, J., Poythress, N. G., & Slobogin, C. (Eds.). (1997). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers* (2nd ed.). New York: Guilford Press.

Miller, K., & Kinkel, S. (2004). Malpractice: The first visit can make or break you. *Journal of the American Chiropractic Association*, 41(4), 44-47.

Miss. Code Ann. § 73-6-17 (2005).

Mo. Code Regs. tit.4, § 70-4.010 (2005).

National Board of Chiropractic Examiners. (n.d.). Retrieved from <http://www.NBCI.com>

Or. Admin. R. 811-010-0095 (2005).

Reed v. Bojarski, 764 A.2d 433 N.J. (2001)

Stanley v. McCarver, 92 P.3d 849 (Ariz. 2004).

Tex. Occ. Code § 201.251-55 (2005).

233 Code Mass. Regs (2005).

Waddell, G. (2004). *The back pain revolution* (2nd ed.). New York: Churchill Livingstone.

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