

Maintaining Objectivity and Consistency and Avoiding Pitfalls in IMEs

C. Donald Williams, MD, CGP, Yakima, WA

Performing Independent Psychiatric Evaluations (IMEs) and testifying at depositions or live in court present challenges similar to those encountered in the conduct of psychotherapy. There are some potential pitfalls not usually faced in psychotherapy that are particular to the role of the independent expert. There are also technical challenges faced by the treating psychiatrist that confront the independent examiner in unexpected ways.

Unintentional or innocently arrived at pitfalls are those that arise from **role confusion** and unconscious **counter-transference** reactions. The responsibility of the independent examiner is to be a seeker of truth, and not to cure. To perform that role with integrity requires informed consent on the part of the person being examined. Many examinees are unsophisticated, and may think that any doctor they see is going to try to help them. *All examinees must be informed of the fact that the evaluation is not for treatment, who is paying for it, that it is not confidential, and where the report will be sent.* This is also a useful intellectual discipline for the independent examiner. The psychiatrist may have been treating another patient the hour immediately before the exam, and it is necessary that they "shift gears," both emotionally and intellectually, to conduct the examination properly.

The second "innocent" pitfall is that of **unexamined counter-transference**, or other intense emotional responses that could contribute to distortion. The personal qualities of examinees, i.e., whether they are "likable," whether they have managed their lives in effective or ineffective ways, as well as their other personal qualities will often have an emotional impact on the examiner. Countertransference, and other emotional reactions, are inescapable. They are a threat to the integrity of the examination process only when the evaluator is not conscious of his/her reaction.

An example might be useful to illustrate this point:

A 53-year-old, 220 pound divorced woman, recovering alcoholic for 13 years, was injured transferring a resident in a nursing home from a commode to a bed. Her pain complaints appear to be in excess of the objective medical findings. She has been out of work and is on public assistance. She is poorly groomed when she arrives at your office, and makes poor eye contact. Her vocabulary and grammar are limited." Or, switch genders and change the occupation to farm worker and the injury to that of having fallen off a ladder from 5 feet.

Discussion: These synopses are

not meant to be complete clinical descriptions, but are intended to illustrate situations in which it might be "normal" for the examiner to discount, distance, and otherwise fail to clearly and completely assess the mental status of the examinee, and dismiss the complaints as exaggeration rather than adequately assess for depressive illness, pain disorder, and other treatable conditions.

Thorough history taking and a careful chart review will lessen the chance of such errors. Knowing oneself well and broad experience treating such patients clinically offer additional safeguards against poor work.

As another example, an IME reviewed recently contained a mental status examination with no report of objective data whatever, but simply asserted that "cognitive functions were grossly normal" on the road to asserting there was no need for psychiatric treatment.

continued on page 4

AOOP Annual Meeting

Join us for our 14th Annual Meeting, entitled "Occupational Psychiatry in the 21st Century: Challenges and Opportunities." The conference will be held January 17-19, 2003 in Washington, DC. Visit www.aoop.org or call 1-877-789-2667 for more information and a copy of the full program.

IN THIS ISSUE

<i>Maintaining Objectivity and Consistency and Avoiding Pitfalls in IMEs</i>	1
<i>Editor's Note</i>	2
<i>Letter from the President</i>	2
<i>Managing Employees in Times of Stress</i>	3
<i>Work Stress in the Military</i>	5

Editor's Note

Jeffrey P. Kahn, MD, New York

As AOOP looks forward to an exciting 14th annual meeting this January in Washington, it seems like just a short time since our 1990 first meeting in Florida. Much has changed since then, and much has continued on course. The work of understanding the roles of work for people, and the roles of people in organizations, is an ongoing clinical fascination. Observing how these relationships change with boom and bust in our economy makes clear the resilience of individuals and organizations, the importance of good leadership and management systems, and the continuing need for OOP skills. A new literature on cost-effectiveness of employer mental health benefits has emerged before our eyes. In the face of changing times, AOOP has also continued to grow and prosper. Dedicated and long term members, continuity of mission, a growing literature, and increasing awareness of our work within the psychiatric community and APA and are but a few of the reasons. The essential role of member activity should be easier to highlight with the advent now of our electronic Bulletin. Please let us know of any OOP topics, members or work (your own or someone else's) that you would like to see featured in the Bulletin or the annual meeting.

Jeffrey P. Kahn, MD is Editor of the OOP Bulletin, President of WorkPsych Associates, and Clinical Associate Professor of Psychiatry at the Weill Cornell Medical College in Manhattan.

Article ideas and suggestions can be sent to him by email to WorkPsych@aol.com.

Letter from the President

Ronald Schouten, MD, JD, Boston, MA

Dear Colleagues:

It has been awhile since our last Bulletin, but I am pleased to report that the field of organizational and occupational psychiatry has continued to grow, and AOOP has been an active part of that. The American Psychiatric Association's Committee on APA/Business Relationships has worked to increase the business community's awareness of mental health issues, and psychiatry's awareness of the needs and concerns of business in this area. Several AOOP members, including Len Sperry, Past President Jeffrey Kahn, and current Treasurer Bob Gordon, have served as members of the Committee.

One product of the Committee's work was the establishment of the National Partnership for Workplace Mental Health, of which AOOP is a member. In April 2002, the Partnership sponsored a conference entitled "Disaster, Terror, and Trauma in the Workplace: What Did We Know Before 9/11 and What Have We Learned Since Then?" I was privileged to represent AOOP and to speak at this conference. Following the conference, the Partnership developed a brochure designed for distribution to businesses: "When Disaster Strikes: Managing Mental Health in the Workplace." You can find out more about the Partnership and download the brochure at www.workplacementalhealth.org.

AOOP will be a co-sponsor for the 8th World Congress of the World Association for Psychosocial Rehabilitation. The Congress will be held in New York City from August 3-5. AOOP members will be entitled to a \$25.00 discount on the registration fee and are encouraged to submit proposals for presentations. Information on WAPR and the Congress can be found at www.wapr.net.

Organizational and occupational psychiatry is attracting attention in other parts of the world, as well. In December, the Japanese Society of Organizational and Occupational Psychiatry will hold its first meeting. Satoru Shima, MD, PhD, a friend and colleague to a number of us, has played a key role in forming that organization. We are hoping to have Dr. Shima join us at our meeting in 2004 and look forward to collaborations with our Japanese colleagues and psychiatrists throughout the world.

continued on page 3

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Letter from the President

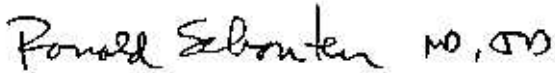
continued from page 2

The AOOB Board believes that international collaboration and direct professional contact is important to us as an organization, and as individuals. To that end, we have modified our membership fees in an effort to attract more international members.

As January approaches, I hope that you have had an opportunity to review the program for our Annual Meeting and the two Pre-conference Workshops. We are excited to offer the programs chaired by Steven Pflanz, Don Williams, Sandy Cohen, and Steve Heidel. These courses represent an expansion of our initiative to develop a curriculum basic to OOP and lower the barriers to entry into the field. If you haven't received your brochure, please contact us by email (staff@aoop.org) or review it on our website (www.aoop.org).

Finally, with this issue, AOOB will change how we distribute the Bulletin. Advances in web publishing allow us to deliver the Bulletin electronically in a reader-friendly format to those of you with email addresses. Electronic delivery is more efficient and allows us to provide more up to date information more economically. You will be receiving a reminder about electronic distribution with your membership renewal and a request for your email address.

Please send us your comments and suggestions for the Bulletin and the Annual Meeting. We encourage contributions for the Bulletin and suggestions for speakers and topics. I am looking forward to seeing you January 17-19 in Washington, DC.



Ronald Schouten, MD JD
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Managing Employees in Times of Stress

by Stephen Heidel, MD, MBA, San Diego, CA

Employees may experience stress due to organizational problems, personal problems, or external events. When any of these problems occur, it is normal for individuals to become preoccupied with the stresses that are impacting their lives and the lives of their loved ones. They may experience strong emotions—including anxiety, anger, fear, insecurity, uncertainty, and depression—that interfere with their ability to concentrate and focus on work. Managers cannot solve every problem they confront, but they are expected to manage problems as they arise. By addressing stressful situations, even those they cannot solve, managers are able to gain the respect of their employees.

General Approach to Managing Employee Stress

The following are guidelines for managers to help identify and deal with employees who are under stress.

- 1. Be alert to concerns and problems that may exist among your employees.** Managers are generally aware of conditions within the organization, such as a possible merger, impending layoffs, dysfunctional workgroup, serious conflict with a coworker, etc. Managers should also be alert to warning signs that indicate an employee may be under stress due to an external event or a personal problem. These warning signs include any change in performance or behavior, such as irritability, isolation, missed work deadlines, unexplained absenteeism, etc.
- 2. Address the concerns immediately.** Respond quickly to warning signs, events or rumors. As soon as a manager becomes aware that one or more employees are under stress, he/she should approach the employee(s).
- 3. Listen to the employees' concerns.** The conversation should begin with simple, open-ended questions, such as "How are things going?" "Is there a problem?" or "I've heard you may be having some problems. Is it true?" These questions will allow the employee to respond in any number of ways, ranging from a vague explanation to being completely frank.
- 4. Respond with empathy.** After inviting the employee to talk and listening to what he/she has to say, the manager should respond in a supportive manner. Remember that 'stress is in the eye of the beholder.' What is experienced as stress by an employee may or may not be experienced the same way by the manager or someone else. The manager should respect the concerns expressed by the employee then respond to those specific concerns.
- 5. Develop a plan.** At the time of the initial meeting with the employee(s), determine if a plan of action is necessary, and if it is, be sure it is conveyed at that initial meeting. The plan might include: 1) further investigation and then getting back to the employee(s) with clarification or further action; 2) asking the concerned employee(s) to consider using resources within the company to address the problems (human resources, medical, or psychiatric evaluation); or 3) agreeing to meet with other employees or the team to get more input.

continued on page 4

6. **Communication/follow up.**

Keep talking to the individuals who are impacted and/or expressing concern. Do not let employees "worry alone" or become isolated from other employees. If the stress is a personal problem involving one employee, the manager should touch base with the employee just to let him/her know that the manager is aware and concerned.

Following is an example of the effectiveness of these steps:

Tim Urban is a 58-year-old senior engineer who has worked for Davidson Engineering for 28 years. He has had an excellent work record. He suffered a serious myocardial infarction. After four weeks his cardiac function was stable and he was released to return to work on a part-time basis at a sedentary computer job. His performance was

fine for about two weeks. He then lost his concentration, withdrew from his coworkers, and became very tired. His boss expressed concern about his health and talked with him about his behavior. Mr. Urban admitted he was not feeling well, but said he had just been to his cardiologist who said his heart was recovering well. A week later his behavior was no better and in some ways was even worse. Mr. Urban had no sense of humor and was making mistakes that were not characteristic of his previous work. His boss asked him if he would go talk to an employee assistance counselor. Mr. Urban acknowledged that he was feeling down and has gotten worse in the past few weeks, despite good reports from his doctor. He agreed to see a counselor who thought he might be depressed. The counselor referred Mr. Urban to a psychiatrist who diagnosed depression.

After talking with Mr. Urban's cardiologist, the psychiatrist prescribed an antidepressant medication. Within four weeks, Mr. Urban was feeling much better and his behavior at work improved significantly. He was very grateful to his boss for steering him to a counselor.

During times of stress and uncertainty, employees look to their manager and their company for support and understanding. Employees know their company cannot solve problems that arise outside the workplace, but they appreciate expressions of concern and support by their manager.

Stephen Heidel, MD, MBA, is a Board Member of AOOP, CEO of Integrated Insights in San Diego, CA, and Associate Clinical Professor, University of California, San Diego School of Medicine.

Maintaining Objectivity and Consistency and Avoiding Pitfalls in IMEs

continued from page 1

A separate psychiatric examination of this person revealed a forward digit span of 4 numbers, an inability to perform serial 3 subtractions, and a volunteered statement that before he would allow himself to lose his home because of financial hardship he would "take steps" to see that his spouse of 35 years was not left homeless. Furthermore, he volunteered that he felt guilty that he was injured (although that made no sense to him), that he felt worthless because he could not contribute financially to the household, and that he felt guilty that he was yelling at his wife for no reason. He couldn't sleep and he lacked the energy to do work around the home that he had always enjoyed. By contrast, a history of his prior workplace injuries revealed a back injury 13 years ago, followed by a 2-year process of successful recovery with physical therapy, work hardening, and a 3.8GPA at a local technical school. He then worked 10 years successfully managing a 5000-acre ranch earning \$40,000 per year.

Not so innocent" pitfalls include consciously accepting work where there is an "expected outcome." Most clinicians do not begin by deciding to

offer dishonest and slanted reports and testimony. Like other ethical lapses, shading findings according to the paying audience in most cases happens gradually and incrementally. The "slippery slope" is easier to resist at the outset than it is when downhill momentum has begun to build. A conscious commitment to apply the same critical standards to all opinions and to subject each of them to review before release is a useful safeguard.

An example of how this can work in practice can be drawn from a recent experience. I had treated, and then terminated for non-compliance, a patient that had a complex history of several prior injuries. Because of the intricacies of case law regarding causality and financial responsibility in the worker's compensation arena, a situation arose in which both counsel for the employer and counsel for the former patient had the same objective; they wanted an opinion that asserted that continuing psychiatric problems were wholly due to an injury from over a decade ago, as it would affect both charges to the most recent employer and benefits to my former patient in a favorable manner. I initially agreed to testify

to this effect, but after a file review and reflection on other similar cases, I realized that the case appeared more appropriate for "second injury fund" resolution. (You can use Google to look this up if you wish) I telephoned the attorney back, advised him that I had reconsidered my opinion, and did not want him to be surprised by the change. He thanked me and cancelled my testimony. I might or might not be correct in my opinion, but that is not the point. The integrity of the process was preserved and I felt comfortable that I was maintaining consistent standards of assessment and opinion.

Other threats to objectivity include overt pressures from referring sources, which may be expressed through assignment questions that are posed in a prejudicial manner and direct challenges to clinical findings, and also more subtle forms. Subtle pressures may be self-inflicted and include limited time, an internal sense of being rushed, and too little opportunity to reflect. For example, a clinician may have work presented by a scheduler

continued on page 5

Work Stress in the Military

By Major Steven Pflanz, MD, Cheyenne, WY

Recent research, published in *Military Medicine* in November 2002, suggests work stress may be an important occupational health hazard for military personnel. Previous research has demonstrated the adverse effects of combat, exposure to heavy casualties, deployment to a war zone, and unexpected mobilizations and trauma associated with humanitarian missions on the emotional functioning of military personnel. However, little research exists on the impact of the routine, peacetime military work environment on the health of military personnel. The existing research has been conducted primarily with military mental health patients. Clearly, conclusions regarding the nature of the military work environment based solely on mental health patient populations are not sufficient.

In this study, 472 military personnel assigned to F.E. Warren AFB in Cheyenne, Wyoming, were questioned using survey methodology. One-quarter (26%) of respondents reported that they were suffering from significant work stress. Nearly one in five (15%) reported that work stress was causing them significant emotional distress. Almost one in ten (8%) reported suffering from work stress that was severe enough to be damaging their emotional health. The report of work stress in the study was independent of age, sex, education, years of military service, rank, and marital status.

Importantly, the military personnel studied were significantly more likely to report work stress than other American workers.

These military personnel did not commonly report military-specific stressors, such as deployment overseas, periodic change of station, involuntary assignment, or frequent duty away from home. Instead, they typically reported job stressors that were common in the civilian arena, such as changes in work responsibilities, work hours, or type of work. Only one of the top five and four of the top ten stressors identified by these military personnel were military-specific. Only one military specific stressor (periodic change of station) was endorsed by more than 10% of the respondents.

Despite the events of the past year, the majority of military personnel over the past 25 years have not served during periods of war. This research and previous studies suggest that the most unique aspects of military jobs, such as deploying overseas in the face of danger, are not the only sources of distress for military personnel. Thus, work stress in the military cannot be simply dismissed by the fact that the business of war is stressful. Previous research has demonstrated that professions with little autonomy and long work hours are associated with increased work stress and psychiatric illness. These factors are often attributes of the military work

environment and may account for some of the job stress in the military.

Given the negative impact of work stress and psychiatric illness on work functioning, it is important for the military to understand and reduce the causes of occupational stress in its personnel. As America moves into the 21st Century, our reliance on the military to protect the nation from terrorism and other threats has increased. This study suggests that additional research on work stress in the military is warranted.

Major Steven Pflanz, MD, is the Program Director for AOOP's 14th Annual Meeting and Chief of Mental Health Services and Deputy Squadron Commander of the 90th Medical Operations Squadron, F. E. Warren Air Force Base. He is also the USAF Space Command Psychiatry Consultant.

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Maintaining Objectivity and Consistency and Avoiding Pitfalls in IMEs

continued from page 4

in a way that seems to demand an opinion on the spot, without time to examine old records and reports. Alternatively, the clinician may take a phone call in which a regular referral source asks a question, makes a plausible comment, and then deferentially asks for a response. In this situation the "natural" response may be to make a polite, compliant, and pleasing response in order to avoid conflict and maintain the appearance of harmony. The response may or not correspond to what the clinician might opine on considered review. What is

important is that the review takes place, and that an unconsidered opinion not be allowed to stand.

In summary, here are several tests one can apply to assess the quality and integrity of ones evaluations and the reports and testimony that result. These include:

- Would the opinion be the same no matter who asked for it?
- Is the opinion consistent with all other opinions you have offered in cases with similar fact patterns?

- Do you have an uncomfortable feeling in the pit of your stomach that something isn't right?
- Would you feel comfortable defending your opinion to an attorney in front of a jury if that attorney had access to all of your IMEs?

C. Donald Williams, MD, CGP is a Past President of AOOP and has a Child, Adult, and Group Psychotherapy private practice in Yakima, WA.