

The Independent Medical Evaluator



Samuel D. Hodge, Jr.

Samuel D. Hodge, Jr. is a professor in the Legal Studies Department at Temple University where he teaches both law and anatomy. He also serves as the Director of the Center for Innovation in Teaching and Learning. He lectures frequently to attorneys, judges, physicians and governmental agencies on medical/legal issues. He is also a skilled litigator who enjoys an AV pre-eminent rating and was named a Top Lawyer in Pennsylvania in 2014. He is a member of the American College of Legal Medicine and American Association of Anatomists and has been awarded a certificate in Anatomy and Law from Temple University School of Medicine. The author would like to thank Therese A. Gentile, M.S.N., M. Ed., R.N., for her invaluable contributions and assistance. Professor Hodge has published more than 150 articles and multiple medical/legal texts. This article is based on a chapter from the author's ALI CLE book, **Anatomy for Litigators, Second Edition**. For more information, please visit www.ali-cle.org/BK80.

Samuel D. Hodge, Jr.

EVERYONE APPROACHES tasks differently, and what may be helpful to one individual may not be to the next. The perfect strategy that was conceived at 10:00 in the morning may prove disastrous at 2:00 in the afternoon. Likewise, each personal injury case is fluid and develops a life of its own. The information provided in this article is offered as a guide when considering whether a medical expert should be consulted in a personal injury claim, and what type of doctor is needed for the job.

Hypothetical Case Study

It is the start of a new week, and you wonder what adventures will transpire before the week is over. You walk to your desk, and there it is, without warning: a new case from the insurance carrier.

You lift the cover of the file as you wonder whether you should first get coffee before reading the materials or whether you should look at the weekend's mail. Oh, what the heck! It's only Monday, and you have the entire week to catch up on the correspondence from the other 300 files lining the perimeter of your office. So, you sit down and begin to read:

Dora Jones was involved in an automobile accident on June 30 of last year.

Your attention, however, is diverted to a large note scrawled on the transmittal letter from the carrier:

Ms. Jones was in an earlier accident on June 1.

Uh, oh!

A quick review of the file reveals that the plaintiff complained of left knee, low back, left elbow, and neck pain, as well as dizziness within the first few weeks following the June 30 accident. Her current complaints include weakness of the lower extremities affecting her gait; bladder incontinence; sleep disturbance; lack of energy; mood swings; headaches; neck, low back, and left elbow pain; and stiffness.

The materials also reveal that following the earlier June 1 incident, Ms. Jones complained of right and left thigh pain, calf and ankle pain, as well as left neck, left shoulder, and left elbow pain. Your interest is now piqued.

The emergency room report from the first accident notes that this 60-year-old woman has a past medical history positive for “neuromas of the feet, and degenerative disc disease of the cervical spine.” There is also a mention of an injury three years earlier that resulted in complaints of lower extremity numbness, lumbar degenerative disc disease, and left knee surgery.

Your initial defense strategy is to play one accident against the other and to argue that all of the plaintiff’s complaints are from earlier problems. To the extent allowed by HIPAA, you subpoena the medical records and diagnostic studies from all health care providers mentioned in the file. As the records trickle in, you diligently organize the documents into subfiles for each incident.

After a few months, the file is bursting with medical documentation and you must decide what is the “right tool for this job.” Should you set up an independent medical examination (IME)? If so, what specialist should be used? After all, the plaintiff has a multitude of complaints and problems that seem to cross several medical disciplines. Should you begin with a film review to document the pre-existing degenerative disc disease, or should you contract for the performance of a medical records analysis?

The decision regarding which “tool” to use may be guided by the information in the file, which

should include the alleged injuries; past and current complaints; signs and symptoms; diagnostic study results; reports from treating specialists, supporting medical documentation; past medical history; the allegations including complaints and parts of the body injured; the opinion of the insurance analyst on what needs to be done; and any financial considerations, constraints, and time limitations.

Medical Records Reviews

A medical records review by the appropriate health care professional will disclose treatment patterns, assist with determining the direction of the file, and place the matter into perspective.

This tool is useful when counsel needs assistance with understanding or establishing the following:

- Past medical or health history and chronology of all information and events;
- Pre-existing conditions;
- Current complaints and diagnoses;
- Cause of the conditions;
- Causal relationship between the accident and claimed injuries;
- Extent of injury or disability;
- Identification of missing records or additional treatment sources;
- Consistencies and/or inconsistencies in the individual’s complaints over time;
- Gaps in treatment, reasonableness or overuse of treatment;
- Appropriate and/or inappropriate specialist referrals;
- Medical necessity of treatment;
- Duration of treatment;
- Type of specialist or specialists to assist with the file;
- Pretrial and litigation strategies; and
- Development of depositions and trial questions

The medical records review can also be used as a preliminary work-up for an IME or in place of one in the event that such an examination is not feasible or attainable. For instance, discovery deadlines may prohibit a medical examination, or counsel for the claimant may refuse the medical or psychiatric examination.

Radiology Review

The MRI in the file reveals that the claimant has a herniated disc in the cervical spine and plaintiff's counsel has demanded the insurance policy limits based upon the test results. First of all, diagnostic findings are not as objective as people think; rather, they reflect the subjective impressions of the radiologist. Studies demonstrate that it is common for physicians to disagree on test results. Also, each diagnostic test produces a number of false-positive findings, and asymptomatic people have abnormal findings. Therefore, a film review is useful in order to establish a baseline, check the accuracy of the diagnosis, and to ascertain the causal relationship between the findings and trauma. If degenerative findings are discovered on the films during the initial months of treatment, testimony should be produced to establish that these conditions pre-existed the accident and could have caused symptoms without intervening trauma.

When considering whether to use a radiological review, counsel should think about the best way to use the images. Radiology reviews can be helpful in determining whether the original diagnosis is accurate and what caused those abnormalities in the first place. If a film review is authorized, counsel should hire a board-certified radiologist who specializes in the area under study. Specialties include the following:

- *Diagnostic radiology.* This specialty uses x-rays, radionuclides, ultrasound, and electromagnetic radiation to diagnose and treat.

- *Radiation oncology.* The study and management of diseases and tumors require a specialist who uses a therapeutic application of radiant energy.
- *Radiological physics.* A physician who specializes in this type of imaging practice uses the diagnostic and therapeutic applications of roentgen x-rays, gamma rays, ultrasound, radiation, and radiofrequency radiation, and the equipment associated with these techniques.

Radiology has become so sophisticated that a number of subspecialties have arisen depending on the imaging modality. These include the following:

- *Neuroradiology.* This specialty assists with the diagnosis and treatment of diseases utilizing imaging procedures relating to the brain, spine and spinal cord, head, and sense organs.
- *Nuclear radiology.* This type of practice uses radionuclides and radiolabeled substances for the diagnosis and treatment of diseases.
- *Pediatric radiology.* Treatment of children presents its own issues; therefore, a pediatric radiologist is one who is experienced in all forms of diagnostic imaging pertaining to newborns, infants, children, and adolescents for both imaging and interventional procedures.
- *Vascular and interventional radiology.* These radiologists specialize in the diagnosis and treatment of diseases with methods that include fluoroscopy, digital radiography, computed tomography, sonography, and magnetic resonance imaging.

Most individuals are familiar with plain x-rays and the fact that they are typically used to visualize anatomical anomalies such as bone fractures and arthritis. X-rays have also been used as a screening tool, a preliminary guide to assist in the diagnostic process, determining the course of care and/or treatment, or to determine if more sophisticated diagnostic studies may be warranted.

Other well-known diagnostic studies include the following:

- *Computed tomography (CT or CAT scan)*. This test uses a specialized x-ray that projects a beam from different angles through the body, thereby producing images that are processed through a computer. These films are presented in cross-sections or “slices.” This type of procedure is most helpful in diagnosing abnormalities in tissue such as those found in the chest and abdominal cavity, including the lung, liver, pancreas, spleen, and kidney, as well as certain musculoskeletal disorders and many types of cancer. Along with the CT’s diagnostic ability, it is also used to plan and assist with treatment and surgery. More detailed areas, such as the knee and shoulder, can be better seen using the MRI. Interpretation requires a radiologist with CT experience, and a neuroradiologist is used for CT scans involving the nervous system.
 - *Magnetic resonance imaging (MRI)*. This modality is considered the gold standard and uses radio-frequency waves and a magnetic field to provide clear visualization of body tissue, internal organs, and structural body parts such as the spine and joints. It is helpful in the detection of musculoskeletal-related injuries of the joints, ligaments, and muscles. It is also used to detect anomalies of the organs and corresponding blood vessels and tissue. This procedure is non-invasive and does not rely on the introduction of any radioactive substance. Interpretation requires a radiologist with MRI experience, and a neuroradiologist is used for MRIs involving the nervous system.
 - *Myleography*. This is the x-ray examination of the spinal cord and space that surrounds the cord. It is used to identify bone and disc pathology. Myleography is an invasive procedure because x-rays are taken only after the injection of a radiopaque contrast through a needle that has been placed in or near the questionable area of the spine. This test, however, has fallen out of favor with some physicians except when the patient cannot undergo an MRI. It is also used as a pre-surgical tool because it provides a road map of the spinal nerves and their location. Interpretation of the film is performed by a radiologist.
 - *Ultrasound (sonography)*. This method produces images of the inside of the body through the use of high-frequency sound waves. Ultrasound is not an x-ray, and it can be used to visualize and show movement within organs such as the heart, liver, spleen, gallbladder, pancreas, kidneys, and bladder. Ultrasound can be used to assist with other diagnostic procedures such as needle placement during a liver biopsy. Interpretation of the test results requires a radiologist with ultrasound experience.
- There are a number of less well-known diagnostic tests that offer great assistance to physicians studying a specific condition or disease process. These include the following:
- *Angiography* is an x-ray that is able to visualize the blood vessels in various parts of the body. This invasive procedure requires a catheter to be inserted into the anatomical area to be examined, and then a contrast material is injected through the catheter into that body part. Once the contrast agent highlights the body part, the x-ray is taken. Individuals may be familiar with the utilization of this test to detect cardiac and blood vessel abnormalities, and interpretation is performed by a radiologist.
 - *Computed tomography angiography (CTA)* is a specialized x-ray that assists with the visualization of blood flow through the veins and arteries. This is a much less invasive procedure than angiography, and a smaller needle is used to pierce and explore a small peripheral vein. Interpretation requires a radiologist with CTA experience.
 - *Magnetic resonance angiography (MRA)* is the MRI study of blood vessels that produces images without the use of a contrast medium. Along

with its diagnostic value, the MRA assists in determining a treatment plan. Interpretation requires a radiologist with MRI experience.

- *Nuclear medicine* is used when it is necessary to evaluate the function of an organ such as the kidney or thyroid. This means that the test is one of physiology. Imaging studies are taken after the introduction of a small dose of a radioactive substance into a vein or by mouth. Analysis of test results requires physicians specially trained in nuclear medicine.
- *Positron emission tomography (PET imaging or PET scan)* is a test of physiology used to detect cancer or follow the progression of cancer treatments. PET scans are also useful to evaluate the function of organs such as the heart or abnormalities of the brain. The scan uses a radioactive substance that is mixed with a natural body compound such as glucose and administered through a vein. Once this material is absorbed by the tissue to be studied, it is detected by the PET scanner. Interpretation is by a radiologist with specialized training in PET scanning.
- *Interventional radiology* is that branch of radiology that focuses on minimally invasive procedures that use imaging for guidance. As compared with open surgery, these procedures do not require large incisions, are less risky and painful, and require less recovery time. Interventional radiologists are board-certified radiologists who specialize in these targeted treatments. Some of the procedures include the following:
 1. *Balloon angioplasty and vascular stenting*, used to improve blood flow to the arteries.
 2. *Cryotherapy* is the application of extreme cold to destroy skin tumors, skin nodules, or skin tags. It has also proven effective for prostate, liver, and cervical cancer.
 3. *Vertebroplasty* is used to strengthen broken vertebrae when they are weakened by osteoporosis. This procedure involves the injection of a cement-like

mixture through a needle directly into the broken bone.

Deciding on an Independent Medical Examination

Keeping in mind that there is no right or wrong way to do things, one of the crucial decisions that an attorney must make in the management of a litigation file is whether the IME is the best “tool for the job.”

Initially, counsel must decide whether an independent medical examination (“IME” can refer to the examiner as well) will be helpful in a case because it can backfire by documenting a clinical finding. If counsel is unsure or not clear regarding the facts or the direction in which to proceed, the IME may not be helpful at that precise moment. There are also times when the results of the IME are not what were anticipated. The IME specialist is not a mind reader and will determine findings based on what medical documentation is presented and the clinical findings on examination.

Counsel should always arrange the medical records in a chronological fashion and present a list of questions that the physician should address. In many cases, this is the only chance counsel will have to obtain input from a medical expert, so one should make the best of the opportunity by guiding the physician through the issues in the case.

The IME is a useful tool in assessing and documenting visual findings or the lack of findings. The IME, when used alone, will assist in determining the claimant’s status at the time of the examination and is similar to taking a snapshot in the middle of a movie. This face-to-face observational tool is useful in determining the following:

- Diagnosis and supporting medical evidence;
- Objective medical evidence or findings;
- Lack of objective medical evidence;
- Cause of complaints;
- Relationship of complaints to the diagnosis or injury;

- Extent of an injury;
- Extent of a disability;
- Effect on activities of daily living, employment, and/or recreational activities;
- Physical capabilities, restrictions, or functional limitations;
- Proportionate or disproportionate response;
- Necessity of past and future treatment;
- Maximum medical improvement; and
- Temporary or permanent impairment.

Specialties To Choose From

Once the decision is made to proceed with the medical examination, who should be chosen to conduct the physical? An orthopedic surgeon is not always the proper choice. Depending on the problem, other types of specialists may be more suitable. Based on the hypothetical case, the following medical specialists could provide useful information.

Physical Medicine and Rehabilitation:

Physiatry

Physical medicine and rehabilitation (PMR), also called *physiatry*, is that branch of medicine that focuses on the prevention, diagnosis, and treatment of disorders of the musculoskeletal, cardiovascular, and pulmonary systems that produce impairment and functional disability.

PMR is one of the 24 medical specialties certified by the American Board of Medical Specialties (ABMS). This type of physician concentrates on non-surgical solutions and restoration of bodily function for individuals who have simple mobility difficulties or more comprehensive cognitive issues. Physiatrists are also responsible for coordinating long-term rehabilitation for people with complicated medical issues such as spinal cord trauma, cancer, stroke, neurological disorders, brain injuries, or amputations, and the major goal of treatment is to restore one's quality of life.

Physiatry came into existence in the 1930s and expanded dramatically after World War II as many

veterans returned with serious disabilities. Physiatrists focused on helping these individuals restore function and deal with chronic pain.

Physiatrists must complete four years of medical school followed by a similar period for residency training with time devoted to developing clinical skills and training in the specialty. Further study is needed to subspecialize in musculoskeletal rehabilitation, pediatrics, traumatic brain injuries, spinal cord injuries, or sports medicine.

Orthopedics

Orthopedic surgery (alternate spelling: orthopaedic) is that branch of medicine that specializes in the diagnosis, correction, care, treatment, rehabilitation, and prevention of injuries and diseases of the musculoskeletal system. That includes the bones, joints, ligaments, tendons, and muscles. Conditions can be acute, chronic, traumatic, and/or recurrent. In addition to mechanical considerations, orthopedists are concerned with pathology, genetics, and the intrinsic, extrinsic, and biomechanical factors of this body system. Orthopedic surgeons use both surgical and non-surgical techniques in their arsenal of treatment options.

Historically, orthopedics was a field dedicated to the treatment of skeletal deformities in children, so the word *orthopedic* was coined. It is, therefore, not surprising that the term is derived from two Greek words: *ortho*, meaning straight; and *paedia*, meaning children.

As with physiatry, many of the developments in orthopedic surgery resulted from experiences during wartime. For example, intramedullary rods to treat fractures of the femur and tibia were found to be effective during World War II, and external fixation of fractures was refined during the Vietnam War.

Orthopedic surgeons undertake between five and seven years of advanced training, and some also spend additional years serving in a fellowship to refine their specialization. Many orthopedic sur-

geons prefer to practice general orthopedics, whereas some specialize in specific areas of the body such as the feet, hands, shoulders, spine, hips, or knees. Some also choose specialized areas of care such as sports medicine or trauma medicine.

Neurosurgery

Neurosurgery is the division of medicine that specializes in treating disorders of the nervous system, including the brain, spinal cord, nerve roots, and nerves. Neurosurgeons are known for their technical skills in these areas. A vast majority of individuals think of neurosurgeons only as brain surgeons; however, they treat much more than the brain. Many neurosurgeons are also back specialists. Although this type of physician generally treats patients with brain and spinal cord disorders, their practice focus may be further subdivided into disc herniations, hydrocephalus, head trauma with hemorrhages and/or fractures, brain tumors, pituitary tumors, cerebral aneurysms, subarachnoid hemorrhages, spinal stenosis, epilepsy, strokes, and Parkinson's disease. Neurosurgeons use both surgical and non-surgical techniques, with focus on prevention, evaluation, diagnosis, treatment, critical care, and rehabilitation of neurological disorders.

In the 1960s, the microscope was introduced into the operating room and revolutionized the practice of neurosurgery. This tool, known as microsurgery, allows neurosurgeons to clearly visualize the minutest details of the body, thereby enhancing the already technically delicate surgery while preserving and not traumatizing surrounding tissue.

Neurosurgeons undergo one of the longest education and training time frames of any of the medical specialties, owing to the complexity of the nervous system and delicate surgical techniques they must perform. Neurosurgeons attend a minimum of five years of advanced post-graduate training, with some programs extending up to eight years. Some neurosurgeons opt to undertake an addition-

al fellowship in their area of study, which adds several years to their training.

It is important to realize that both neurosurgeons and orthopedic surgeons are considered spine specialists and perform surgery to this area. Neurosurgeons and orthopedic surgeons are skilled in taking care of disc herniations, disc degenerations, spinal stenosis, fractures of the spine, spondylolisthesis (slippage of the spine), scoliosis, and bone tumors. Neurosurgeons, however, are the only ones who have been trained to perform procedures inside the lining of the spinal canal or the dura. Therefore, neurosurgeons treat and diagnose disorders that may include spinal cord tumors, arachnoid cysts, syringomyelia, a tethered spinal cord, spina bifida, and nerve root tumors.

Neurology

Neurologists specialize in diagnosing, treating, and managing disorders of the brain, spinal cord, nerves, muscles, and pain. Common conditions treated include headaches, stupor and coma, dementia, Alzheimer's disease, seizures and epilepsy, sleep disorders, cerebral palsy, tumors, Parkinson's disease, multiple sclerosis, spinal cord disorders, and maladies of the muscles and neuromuscular junctions. Neurological examinations include muscle strength and movement, balance, coordination, ambulation, reflexes, sensation, vision, memory, speech, language, and other cognitive abilities. These physicians also determine what area of the brain and/or nervous system may be affected. Although neurologists can recommend surgery, they, themselves, use only non-surgical techniques.

Prominent neurologists include Alois Alzheimer, a German physician who first observed the symptoms of Alzheimer's disease in 1906; and Joseph Babinski, a French neurologist who described the pathological sign of plantar flexion known as the *Babinski sign*. Mortiz Heinrich Romberg, a German neurologist, discovered the *Romberg sign* in his original account of the effects of syphilis. This sign

was noted to include a loss of sense of position, unsteadiness, or falling with the eyes closed.

Neurologists attend at least one year of postgraduate study in either internal medicine or medicine/surgery and at least three years of specialty resident training.

BOARD CERTIFICATION AND CREDENTIALS • Prior to discussing board certification and what constitutes the appropriate credentials for a medical expert, the reader should be aware of an article authored by Dr. Steven Dubrow Eichel discussing credentialing and medical certifications.¹ This author drives home the point on how careful counsel should be when selecting a specialist.² The subject of the story was Dr. Katze, a Philadelphia-based psychologist.³

Zoe D. Katze, Ph.D., C.Ht., DAPA, was contacted by a major journal for input on an article about using hypnosis during childbirth.⁴ The reporter located Dr. Katze's name on the Web site of the American Association of Professional Hypnotherapists.⁵ Dr. Katze's credentials certainly looked impressive. She was certified by the National Guild of Hypnotics, the American Board of Hypnotherapy, and the International Medical and Dental Hypnotherapy Association.⁶ Diplomate status was achieved with the American Psychotherapy Association, and she was a member of the American Association of Professional Hypnotherapists. Dr. Katze held a Doctorate in Counseling Psychology and a M.S. in Clinical Hypnotherapy.⁷ The important point, however, is that Zoe D. Katze was Dr. Eichel's cat, and the author demonstrated how easy it is for one to obtain a variety of certifications and to build a resume that looks very impressive.⁸

Physician Training

Training to become a doctor is an intensive process that starts with four years of medical school. After receiving a Doctorate of Medicine, or M.D. degree, most physicians will seek at least three more

years of training in their selected medical specialty during a residency program. Residency is a full-time, supervised experience in a hospital or ambulatory care facility, which may last from three to seven years. If the doctor then decides to subspecialize, another one to three years of training may be necessary.

Specialties range from generalists, such as primary care, family medicine, internal medicine, and general surgery, to concentrating on a specific body part, system, age group, or type of disorder.

Licensing

The practice of medicine mandates that a doctor be licensed. This process is governed by each state and requires that a physician pass an examination that is administered by the appropriate state board of medical examiners. Most states also require at least one year of additional postgraduate medical training, prior to sitting for the examination.

Passing this test secures the privilege to practice in the state for which the examination was taken. A medical license, however, is for the general practice of medicine and/or surgery and does not recognize specialty practices.

Credentialing

Counsel is best served by contacting a "credentialled" specialist when a physician is needed in a claims setting. In reviewing a stack of curriculum vitae to make that selection, one's eyes soon begin to cross from all the letters after the physician's name. What do all these initials mean, and should they be taken seriously?

Boards fall into two categories: those that are associated with the American Board of Medical Specialties (ABMS) and those that are not, or non-ABMS. There are a number of unofficial certifications that are issued from "boards" that require no examination and little or no additional education, training, or experience. Physicians who rely solely

upon non-recognized board certification are easily subject to impeachment at trial. During the qualification stage of the expert's testimony, counsel will be well advised to understand what is and is not an approved board certification. Although the initial reaction may be to stipulate to the opposing physician's expertise, that may be the wrong strategy if the doctor does not have strong credentials.

Specialty boards will only certify physicians after they have met certain published standards. Currently, only 24 specialty boards are credentialed by the ABMS and recognized by associate members composed of the American Medical Association (AMA), American Hospital Association, Association of American Medical Colleges, Council of Medical Specialty Societies, Federation of State Boards of the United States, and National Board of Medical Examiners. Board certificates are also available for approximately 37 specialties and 75 subspecialties. Certifications often expire within 6 to 10 years and require reexaminations to maintain the board certification. The American Osteopathic Association (AOA) also establishes standards for osteopathic physicians. The ABMS, however, will certify osteopathic physicians who train at M.D. run programs. (A list of the ABMS specialist and subspecialist certification areas can be found at <http://www.abms.org/member-boards/specialty-subspecialty-certificates/>).

The ABMS is a non-profit organization that oversees physician certification in the United States. The mission of this organization is to maintain and improve the quality of medical care in the United States. This is accomplished through the implementation of educational and professional standards. Each board decides the extent and scope of training and requirements for its own members.

To be eligible for certification by ABMS, applicants must complete a course of study leading to an M.D. or D.O. from a recognized school of medicine. They must have a state license to practice, complete the required years of full-time specialty

training at an accredited residency program, provide the required written documentation regarding their individual performance, and pass a written and/or oral examination given by the specialty board. Once all of these requirements are satisfied, the physician is awarded the status of "Diplomate" and receives certification in the selected specialty.

Verification of Credentials

Certified medical specialists are listed in *The Official ABMS Directory of Board Certified Medical Specialists* published by Marquis Who's Who.⁹ This information can also be obtained from county medical societies, the ABMS, or the specific specialty board. Counsel can also call 1-866-ASK-ABMS or use the ABMS Web site at www.abms.org.

Most board-certified physicians are members of the societies of those medical specialties. Quite a few of the medical societies require board certification for a full membership. Doctors who are full members of their respective medical specialty society are known as "Fellows."

Non-Approved Certifications

As demonstrated by the story of Dr. Katze, determining whether a physician is board certified (or even a human) can be a daunting, but important task. Counsel must have confidence that the expert is qualified and has the necessary experience to assist in the case. Some physicians, however, are less than straightforward with their credentials. They proudly display a number of board certifications that are not from recognized agencies. There is nothing wrong with belonging to these special interest groups, but physicians should not make it seem as though these organizations are equivalent to the ABMS. There are many credentialing organizations that incorporate the word "Board" or "Board Certified" into their name and issue certificates, even though there are little to no requirements for that certification. There is no standardization of

credentialing, and certification is often done solely through the submission of an application fee.

Titles, academic degrees, and specialties should provide accurate information regarding the specialist's education, training, and experience. There are individuals, however, who use titles and abbreviations to impress others, which is self-serving and misleading. One of the best ways to determine legitimacy is to ask the physician, "What do the initials stand for?" Also, counsel should ask the following: How did the doctor obtain the certification, and what were the requirements? How many years of experience were needed? What type of certifying examination was taken, and was it written and/or oral? If you are unsure, have the doctor explain the process used to obtain the board certification. There is nothing wrong with letting the expert know that you are unfamiliar with the credentials and/or board certification and ask the doctor to provide a telephone number or Web site for the board so the information can be verified. There should be no hesitation on the part of the physician to educate counsel regarding one's professional achievements. Answers to these questions will also help the attorney separate "just paper" from substance.

Board Eligible/Qualified

It is common to encounter the terms "board eligible" or "board qualified." What do these terms mean? Physicians who are "eligible" to take their specialty board have met the requirements of training and experience in order to sit for the boards. Physicians who have applied and are scheduled to take their examinations are considered "qualified." Neither, however, are board *certified*.

THE IDEAL SPECIALIST • At the very least, the ideal specialist should have undergone the appropriate training and have an unrestricted license to practice medicine. These individuals should also possess verifiable credentials and approved board certification in their field of practice.

The ideal specialist needs to be well versed in the diagnosis, standards of care, and treatment in question, and be in active practice within his or her discipline. The physician should be able and willing to spend the time necessary to review the medical records, test results, diagnostic studies, and any legal documentation available. The expert should also be skilled in the art of taking a medical history and have the ability to verify and clarify statements made during an examinee's interview and physical.

It is important that the specialist be easily accessible throughout the life of the file. Questions arise following depositions or after the receipt of new medical information, and the physician must be available for consultation. The doctor's attitude should be professional, calm, and focused, and reports should be chronologically prepared and easy to follow. Many times, the doctor's report forms the basis for the scope and order of the questions at trial. Therefore, the ideal specialist should present a credible report that is clear, accurate, factual, and concise, with all opinions supported by objective medical evidence. There should also be clear and direct language, which demonstrates how logical conclusions were drawn from the facts.

Finally, when choosing the proper specialist, communication becomes counsel's most important tool. You need to know your expert and understand the doctor's area of expertise. All specialists have certain strengths and can be extremely valuable in assisting and providing insight into the medical issues within the case. If counsel can successfully communicate with the physician by learning how to speak the same language, and develop a clearly defined course of action, the chances of achieving an effective and favorable resolution will have been increased.

LEGAL CONSIDERATIONS • Several issues occasionally appear when the defense requests an IME with a particular physician. Some counsel for the claimants may refuse to allow a specific doctor to perform the examination, claiming that the doctor is biased in favor of insurance companies, and

questions arise as to whether the examinee may have a witness present during the examination. An issue has even arisen as to whether the physician and insurance company can be liable for the erroneous report of the medical specialist who examines the patient.

Qualifications

A couple of interesting questions have arisen concerning the qualifications of the doctor performing the IME.

The New York Court of Appeals was asked to address the question as to what is meant by being board certified. The Injured Workers' Protection Act provides that only *board-certified* physicians are authorized to perform IMEs. The court ruled that the term requires approval by an appropriate medical specialty board of the American Board of Medical Specialties and American Osteopathic Association.¹⁰ It does not encompass boards of other organizations.¹¹ This mandate "provides a greater level of quality assurance as the physicians authorized to perform IMEs have attained a certain degree of professional competency as recognized by the certifying boards."¹²

Another case dealt with whether a clinical psychologist was qualified as a physician under the workers' compensation laws of Montana.¹³ The court ruled that the term *treating physician* did not encompass the profession of clinical psychology.¹⁴ Therefore, the insurance carrier was not allowed to use the opinion of this type of specialist to refute the claimant's allegations of depression and psychosis.¹⁵

Bias of the Medical Expert

A number of attempts have been made to prevent the claimant from being examined by a specific physician, claiming that the doctor was biased in favor of the insurance carrier. For the most part, these attempts are unsuccessful because the issue is more one of credibility to be addressed at trial. The courts have noted that the purpose of allowing the IME is to provide "a level playing field between

the parties. Defendants have no say in determining what physician plaintiff chooses as his or her expert witness."¹⁶

For example, in *Claudia Douponce v. Mary Drake*,¹⁷ the plaintiff moved for a protective order to prevent her examination by a specific doctor on the basis that he was biased in favor of defendants. The facts demonstrated that the physician in question had performed numerous medical examinations for defense clients.¹⁸ The court denied the motion and ruled that the suggestion that certain doctors testify only for the defense in matters of personal injury does not suggest bias and prejudice.¹⁹ Such matters are relevant only as to the weight and credibility of the opinion, and cross-examination on this subject affords full protection to the plaintiff's rights.²⁰

A contrary result was reached in *Michael White v. State Farm Mutual Automobile Insurance Company*.²¹ There the plaintiff was successful in preventing a certain physician from examining the claimant because the doctor would act only as an advocate for the carrier.²² The court noted that as a general rule, there exists a presumption that a physician in a personal injury action will properly conduct a physical examination of the plaintiff.²³ This presumption, however, can be overcome by a doctor's documented, history of partiality.²⁴ In this case, a number of reported decisions had commented on the doctor's statements, which showed bias.²⁵ The court, therefore, concluded that the physician's testimony would be of little value because of his bias and statements.²⁶ Moreover, no credence can be given to the complaints of parties involved in litigation because of their secondary gain motives.²⁷

Can a Representative of the Plaintiff Be Present at the IME?

A number of states have rules and legislative enactments on whether the plaintiff may have a representative present at the IME. The rationale for allowing someone to accompany the claimant is that counsel's presence may protect the examinee from being improperly questioned on liability issues, or provide the claimant with comfort and support.²⁸

The courts, however, do not always permit counsel for the claimant to be present. New York and Florida allow attorneys to be present as a matter of course.²⁹ California allows either party to request a court reporter to transcribe what is said at the examination.³⁰ The litigant is also entitled to have an attorney present during the examination.³¹ Wisconsin and Oregon, however, have placed the burden on the plaintiff to demonstrate why his or her attorney should be present.³² The federal courts have held that the plaintiff's attorney may not be present during these examinations.³³ New Jersey adopted the approach followed by Wisconsin and Oregon, which place the decision within the discretion of the trial court and the burden on the claimant's attorney who wishes to attend or record the event.³⁴

Video or Tape Recording the Examination

Should plaintiff's counsel be allowed to videotape or audio record the examination? It is argued that the videotape of the IME is required to ensure both an adequate examination and a fair procedure for all parties. The court denied this request in *Lynn Astill v. Leesha Clark*,³⁵ because there was no showing that the plaintiff would be unable to produce her neurologist to monitor the IME.

A number of courts have refused to allow a tape recorder to be used during an IME. For instance, in *Shirsat v. Mutual Pharmaceutical Company*,³⁶ both a court reporter and tape recorder were not allowed to be present during a Rule 35 examination. The plaintiff's request to tape record a court-ordered medical examination was refused in *Hayes v. District Court*.³⁷ Finally, in *Shirsat v. Mutual Pharmaceutical Co.*,³⁸ a court reporter and recording device were not allowed during the examination by defendant's psychiatrist because the person would have constituted a distraction and would diminish the accuracy of the examination process.

Other courts have allowed an audio recorder, stenographer, or video camera in the examination

room. For instance, in *Sidari v. Orleans Cty.*,³⁹ the court allowed an audio recorder to be used, and a video camera was permitted in *Zabkowitz v. West Bend Co.*⁴⁰ Indiana allows either party to record the event in the absence of some overriding reason to prohibit the recording.⁴¹

In some jurisdictions, the right to have a camera or recorder in the examination room is provided by the rules of the court. For example, Arizona Rule of Civil Procedure 35(a) allows for the sound recording of an examination and videotaping may be requested upon a showing of good cause. California Code of Civil Procedure §2032.510(a) provides that an attorney may record the proceeding.

Suing the IME Doctor or Insurance Carrier

May a disgruntled claimant successfully sue the physician who performed the IME and the insurance carrier that hired the physician? That was the issue in *Martinez v. Jeanne C. Lewis*.⁴² The plaintiff was injured in a car accident and sought psychological care for her injuries.⁴³ A physician hired by the carrier concluded that the claimant was malingering and her benefits were denied, resulting in a 16-month delay before she could obtain treatment.⁴⁴ This triggered a claim against the IME doctor for professional negligence.⁴⁵ The court dismissed the lawsuit on the basis that no physician-patient relationship existed.⁴⁶ The doctor was hired by the carrier solely to comment on the nature and extent of the claimant's injuries in order to determine whether to pay the medical bills submitted to the carrier.⁴⁷

As the court in *Martinez* noted, similar results have been reached in other jurisdictions. In *Hafner v. Beck*,⁴⁸ the court ruled that because no physician-patient relationship existed, no duty ran from the IME to the examinee. Rather, the duty extended from the IME to the insurance carrier.⁴⁹ A similar result was reached in *Keene v. Wiggins*.⁵⁰ This California court ruled that when a doctor conducts an examination of an injured employee solely for pur-

poses of rating the injury for the employer's workers' compensation insurance carrier, the doctor is not liable to the person being examined for negligence in making that report.⁵¹ Michigan weighed in on this issue in *Rogers v. Horvath*,⁵² by stating that a doctor who neither advised nor treated the plaintiff did not owe the claimant a duty arising from a doctor/patient relationship, even when the plaintiff lost benefits from the insurance company based on the doctor's examination.

A couple of pronouncements, however, have placed these rulings in question. The American Medical Association started the ball rolling in 1999 with Opinion 10.03 entitled "Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations." The AMA stated that when a physician performs an isolated assessment of a person's health or disability for an employer, business, or insurance carrier, a limited patient-physician relationship should exist.

In *Stanley v. McCarver*,⁵³ a radiologist evaluated a chest x-ray as part of a pre-employment screening. The doctor found an abnormality and noted this finding on his report.⁵⁴ The employer, however, did not tell the plaintiff, who was subsequently diagnosed with lung cancer.⁵⁵ Despite the absence of a traditional doctor-patient relationship, the court stated that the physician undertook a professional obligation to the plaintiff with respect to her well-being.⁵⁶ Therefore, the radiologist should have anticipated that the employee would want to know of the potentially life-threatening condition and he should have acted with reasonable care in light of that knowledge.⁵⁷

A similar ruling was issued in *Dyer v. Trachtman*,⁵⁸ where the court noted that when a physician performs an IME, a limited physician-patient relationship is created. This limited relationship encompasses a duty by the examiner to exercise care consistent with the doctor's professional training and expertise so as not to cause physical harm by negligently conducting the examination.⁵⁹

CONCLUSION • The defense is allowed to level the playing field by hiring a physician or physicians to review the medical records and diagnostic studies and to opine on whether the treatment is reasonable and medically necessary. Also, the plaintiff can be required to see a doctor for the purpose of an IME. Choosing the right doctor, however, is critical and has a bearing on the success of the defense. Counsel must make sure that the physician can stand up to the scrutiny of an aggressive cross-examination. This requires that the doctor be properly credentialed and that all reports be supported by the facts. It serves no purpose if the doctor merely states what counsel wishes to hear. The examiner must provide a clear and logical opinion that is based on sound reasoning. Because doctors are not mind readers, defense counsel should always place the medical records in a chronological fashion so that they tell a story and supply the medical examiner with a list of questions that should be addressed. By following the basic rules discussed in this article, it is hoped that counsel's chances of obtaining a more logical outcome will be improved.

PRACTICE CHECKLIST FOR THE INDEPENDENT MEDICAL EVALUATION

- A medical records review will disclose treatment patterns, assist with determining the direction of the file, and place the matter into perspective. The physician can assist in documenting pre-existing conditions; the causal relationship between the accident and claimed injuries; consistencies and/or inconsistencies in the individual's complaints; reasonableness or overuse of treatment; and medical necessity of treatment.
- Diagnostic findings reflect the subjective impressions of the radiologist, and each diagnostic test produces a number of false-positive results. Asymptomatic people also have abnormal findings. Therefore, a film review is useful to establish a baseline, check the accuracy of the diagnosis, and to ascertain the causal relationship between the findings and trauma.
- Types of subspecialties in radiology include diagnostic radiology, radiation oncology, and radiological physics.
- When arranging for an independent medical examination (IME), counsel should always arrange the medical records in a chronological fashion and present a list of questions that the physician should address.
- The IME is a useful tool in assessing and documenting visual findings or the lack of findings. This tool is useful in determining diagnosis and supporting medical evidence, lack of objective medical evidence, the relationship of complaints to the diagnosis or injury, the extent of disability, and the necessity of future treatment.
- There are a number of medical specialties that are useful in conducting the IME. Although the initial reaction of many attorneys and claims adjusters is to utilize an orthopedic surgeon, that may not be the best choice. Other options include a neurologist, neurosurgeon, or physiatrist.
- Boards fall into two categories: those that are associated with the American Board of Medical Specialties (ABMS), and those that are not, or non-ABMS. It is important for counsel to know the difference between these two categories.
- It is common to encounter the terms "board eligible" or "board qualified." Physicians who are "eligible" to take their specialty board have met the requirements of training and experience in order to sit for the boards. Physicians who have applied and are scheduled to take their examinations are considered "qualified." Neither, however, is board *certified*.

RESEARCH TOOLS

West Key Numbers

No Physician-Patient Relationship Between Plaintiff And IME Doctor.

Key Number: 198H Health, subsection 198Hk576.

Duty Of Care Of IME Doctor.

Key Number: 198H Health, subsection 198Hk709.

Bias Of IME Doctor Under Federal Rules Of Civil Procedure.

Key Number: 170A Federal Civil Procedure, subsection 170AX(F).

Attorney At IME.

Key Number: 307A Pretrial Procedure, subsection 307AII(f).

Having Plaintiff’s Doctor At IME.

Key Number: 115 Proceedings for Assessment, subsection 115k206.

Videotaping Of The IME.

Key Number: 115 Damages, subsection 115k206.

Defense’s Right To Select The IME doctor.

Key Number: 115 Damages, subsection 115k206.

Qualifications Of The IME Doctor.

Key Number: 413 Workers’ Compensation, subsection 413k1310.

American Law Reports

“Right of Party to Have Attorney or Physician Present During Physical or Mental Examination at Instance of Opposing Party,” 84 A.L.R.4th 558 (1991)

American Jurisprudence

Qualification of Medical Expert Witness, 33 Am. Jur. Proof of Facts 2d 179 (1983)

BIBLIOGRAPHY

1. American Academy of Physical Medicine and Rehabilitation, available at www.aapmr.org (last visited Oct 2015).
2. American Board of Medical Specialties, available at www.abms.org (last visited Oct. 2015).
3. American Medical Association, available at www.ama-assn.org (last visited Oct. 2015).
4. Answers Corporation, available at www.answers.com (last visited Oct. 2015).
5. ABMS Solutions, available at www.abmssolutions.com (last visited Oct 2015).
6. Remedy’s health.com communities, available at www.healthcommunities.com (last visited Oct. 2015).
7. American Association of Neurological Surgeons, available at www.aans.org (last visited Oct. 2015).
8. Women in Neurosurgery, available at www.neurosurgerywins.org (last visited Oct. 2015).
9. Radiological Society of North America, available at www.radiologyinfo.org (last visited Oct. 2015).
10. Back Institute, available at www.backinstitute.com (last visited Oct. 2015).
11. spineuniverse, available at www.spineuniverse.com (last visited Oct. 2015).
12. Wikipedia, available at www.wikipedia.org (last visited Oct. 2015).

ENDNOTES

- 1 This article on credentialing may be found at *Credentialing: It May Not Be the Cat's Meow*, available at www.dreichel.com/articles/dr_zoe.htm (last visited Oct 2015).
- 2 *Id.*
- 3 *Id.*
- 4 *Id.*
- 5 *Id.*
- 6 *Id.*
- 7 *Id.*
- 8 *Id.*
- 9 *Id.*
- 10 *In the Matter of Dominic Belmonte v. Robert Snashall*, 813 N.E. 2d 621 (N. Y. 2004).
- 11 *Id.*
- 12 *Id.*
- 13 *EBI/Orion Group v. Michael Blythe*, 931 P. 2d 38 (Mont. 1997).
- 14 *Id.*
- 15 *Id.*
- 16 *Looney v. National R.R. Passenger Corp.*, 142 F.R.D. 264, 265 (D. Mass. 1992).
- 17 183 F.R.D. 565, 43 Fed. R. Serv. 3d 249 (D. Colo.1998).
- 18 *Id.*
- 19 *Id.*
- 20 *See also Larsen v. New*, 812 A.2d 220 (Conn. Super. Ct. 2002).
- 21 680 So. 2d 1 (La. Ct. App. 1996).
- 22 *Id.*
- 23 *Id.*
- 24 *Id.*
- 25 *Id.*
- 26 *Id.*
- 27 *Id.*
- 28 Thomas M. Fleming, Annotation, *Right of Party to Have Attorney or Physician Present During Physical or Mental Examination at Instance of Opposing Party*, 84 A.L.R. 4th 558 (1991).
- 29 *See Reardon v. Port Auth.*, 503 N.Y.S.2d 233, 234-235 (N.Y. Sup. Ct. 1986); *Bartell v. McCarrick*, 498 So.2d 1378, 1379 (Fla. Dist. Ct. App. 1986).
- 30 *Gonzi v. Superior Court*, 335 P.2d 97 (Cal. 1959).
- 31 *Sharff v. Superior Court*, 282 P.2d 896 (Cal. 1955).
- 32 *See Whanger v. American Family Mutual Ins. Co.*, 207 N.W.2d 74 (Wis. 1973); *Pemberton v. Bennett*, 381 P.2d 705 (Or. 1963).
- 33 *See Shirsat v. Mutual Pharmaceutical Co., Inc.*, 169 F.R.D. 68 (E.D. Pa. 1996); *Brandenberg v. El Al Israel Airlines*, 79 F.R.D. 543 (S.D. N.Y. 1978).
- 34 *Briglia v. Exxon Company, USA*, 798 A.2d 1246 (N.J. Super. Ct. Law Div. 1997).
- 35 956 P.2d 1081, (Utah Ct App. 1998).

- 36 *Shirsat*, supra 169 F.R.D. 68 (E.D. Pa. 1996).
- 37 854 P.2d 1240 (Colo. 1993).
- 38 *Shirsat*, supra 169 F.R.D. 68 (E.D. Pa. 1996).
- 39 174 F.R.D. 275 (W.D .N.Y .1996).
- 40 585 F. Supp. 635 (E.D. Wis. 1984).
- 41 *See Jacob v. Chaplin*, 639 N.E.2d 1010 (Ind. 1994).
- 42 942 P. 2d 1219 (Colo. Ct. App. 1997), *aff'd*, 969 P.2d 213 (Colo. 1998).
- 43 *Id.*
- 44 *Id.*
- 45 *Id.*
- 46 *Id.*
- 47 *Id.*
- 48 916 P.2d 1105 (Ariz. Ct. App. 1995).
- 49 *Id.*
- 50 138 Cal. Rptr. 3 (Cal. Ct. App. 1977).
- 51 *Id.*
- 52 237 N.W.2d 595 (Mich. Ct. App. 1975).
- 53 208 Ariz. 219, 92 P.3d 849 (Ariz. 2004).
- 54 *Id.*
- 55 *Id.*
- 56 *Id.*
- 57 *Id.*
- 58 679 N.W. 2d 311 (Mich. 2004).
- 59 *Id.*