Disabled Doctors: The Insurance Industry Seeks a Second Opinion

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This article focuses on disability in the professional work force, especially among physicians, and includes a background on private disability insurance in the United States, a discussion of problems experienced by the insurance industry over the past few years, a review of relevant case law on private disability, and legal and clinical issues involved in performing independent medical evaluations.

Disability insurance is crucial for workers. A 1990 report from the Centers for Disease Control (Atlanta, GA) indicated that 12.8. million individuals in the United States had a "work disability."[1] Disability insurance programs are traditionally divided into two categories: (1) social disability insurance, including Social Security programs, civil service disability pensions, and state workers' compensation programs; and (2) commercial insurance policies, including group plans and individual plans.[2] As social disability programs continue to expand, forensic clinicians have become increasingly aware of the difficulty of reconciling disability as a medical concept with disability as an economic concept. Social disability insurance programs are difficult to administer, and their scope and costs are dependent on the definition of disability used by the program. Social disability insurance programs are sensitive to economic conditions; even if the formal definition of disability is very strict, labor market conditions influence both the rate of applications and the adjudication of disability claims.[3]

Despite awareness of issues in social disability insurance programs, less attention has been paid to problems experienced by private commercial insurance companies. Historically, higher socioeconomic status has been associated with fewer claims and shorter duration of claims. Individuals with private disability insurance policies are usually well educated, tend to be self-employed, and include physicians, attorneys, and business executives. Currently, about three million

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Table 1
Insurance Terms Commonly Used in Disability Insurance Plans

Insurance Term	Definition
Noncancellable guaranteed renewable	Usually, the insurance company cannot increase premiums or change contract language until the insured reaches age 65. As long as premiums are paid, the policy cannot be canceled.
Guaranteed renewable	The insurance company can increase premiums for the entire group or class of professionals and can change contract language. (However, the insurer cannot make these changes to individual policy members.)
Waiting period	The time period before benefits start. Waiting periods can be as little as seven days or as long as two years. The longer the waiting period, the lower the premiums.
Benefit period	The amount of time monthly benefits for disability can be received under the terms of the policy.
Own occupation clause	If the insured is unable to perform the duties of a specialty occupation, benefits are payable even if the insured can perform in another job and regardless of other income.
Any occupation clause	If the insured is unable to perform duties of a specialty occupation, benefits are not payable if the insured can perform in another job.
Recurrent disability clause	This clause covers repeated but separate periods of disability caused by the same illness or injury.

people, many of them self-employed, are covered by individual disability policies that generate about 3.5 billion dollars a year in premiums for the insurance industry.[4] Recent changes in private disability insurance have resulted in problems not traditionally thought of as occurring in the private sector. This article focuses on disability in the professional work force, especially among physicians, and includes a background on private disability insurance in the United States, a discussion of problems experienced by the insurance industry over the past few years, a review of relevant case law on private disability, and legal and clinical issues involved in performing independent medical evaluations (IMEs).

Private Disability Insurance

Background on Private Disability In the United States, private disability insurance preceded the development of social disability insurance. In the decade that began in 1910, disability clauses became more readily available in life insurance policies (for a definition of terms commonly used in these policies, see Table 1). Most companies narrowly defined disability as a condition in which a claimant was "wholly and permanently, continuously and wholly prevented from performing any work for compensation or profit." In 1922, a "professional man's clause" was introduced by one company; disability was defined as "inability to per-

form the duties of [one's] occupation."[5] These clauses became fairly standard in the 1920s.

Professional private disability insurance historically provided great market potential for insurance companies because insurers could rely on encountering a favorable work ethic when dealing with professionals.[6] Self-employed people, primarily doctors and lawyers, often had to buy their own disability insurance coverage. For years, insurance companies were eager to enroll physicians and attorneys because they could afford insurance premiums and rarely put in a claim. Physicians in particular tended to be disabled less often and for shorter periods of time.

The 1980s began as a period of growth and competition in the private disability insurance industry. Industry profitability was good; this attracted new insurance companies that were eager to gain market share. New insurance carriers brought lower rates and more competitive products. This, in turn, prompted existing carriers to become more competitive to retain market leadership. Contract language, underwriting, and pricing structures were liberalized, and many companies achieved record growth during this period.[7]

Increasing Claims in the 1990s In recent years, increasing numbers of physicians have been going out on claim. Incurred claims increased from 43.5 percent of premiums in 1980 to 77.3 percent in 1992. At Paul Revere Insurance Group, the largest supplier of individual disability insurance in the United States, the entire client base of professionals—including physicians—filing disability claims increased by 62.5 percent from 1989 to 1994. In addition, physicians who go out on claim are not returning to work as quickly as they did in the past.[8]

From the insurance industry's point of view, the problem of increased claims is greatest among physicians, especially those in five specialties: orthopedic surgery, neurosurgery, anesthesiology, emergency room service, and thoracic surgery. The type of claim most often filed is for musculoskeletal, non-back-related injury. Significant increases in claims by physicians have also been seen for carpal tunnel syndrome, Epstein-Barr syndrome, psychiatric disorders, and AIDS. At Paul Revere, 75 percent of psychiatric ("mental-nervous") claims are for depression, and psychiatric claims constitute 18 percent of the total claims payouts (compared with 35% of total claims payouts for musculoskeletal claims and 16% of total claims payouts for cardiac claims). At other disability insurance companies, the duration of psychiatric claims is now longer than for any other type of claim.

Insurance companies cite the following reasons for the recent increase in claims by physicians. These problems are not necessarily independent of each other.

- *The subjective nature of disability claims, both psychiatric and nonpsychiatric.* Independent medical evaluators can, at times, legitimately disagree about whether a person is disabled. For several reasons, psychiatric claims can be particularly difficult: physician claimants may realize the ease of feigning some psychiatric symptoms; psychiatric illnesses often lack standardized treatment plans for

the same problem; and claimants' personal psychiatrists often inform the insurance company that revoking reimbursement will cause a relapse of the claimant's psychiatric condition.

- *Particularly liberal policies issued between 1985 and 1989.* In the 1980s, the incidence of submitted claims was lower, and competition for business led many insurance companies to offer favorable terms to customers. Policy changes in the mid-1980s that were designed to attract customers and that are now causing problems include: unisex rates (initiated with the expectation, ultimately proven wrong, that increasing proportions of professional women would improve female morbidity rates that have historically been higher than male morbidity rates); "own-occupation" definitions of disability that have become more generous and more common in the last 20 years; liberalized underwriting and lax enforcement of existing policy provisions; and longer benefit periods, particularly the wide availability of lifetime benefits.
- *Managed care.* Today, more than 65 percent of companies with 200 or more employees belong to managed care systems. Managed care companies restrict referrals, require approval for many tests, and dictate fees. With managed care, physicians frequently experience diminished job satisfaction, and salaries are often negatively impacted. California and Florida have had especially high managed care penetration along with high sales volume for private disability policies to physicians. These states are experiencing physician disability claims at five times the expected rate.
- *Increased work pressures.* Some hard-working doctors could be forced out on disability. The economics of running a practice has become so tight that it may be difficult to do unless the doctor is in good physical condition and can work at peak capacity. Many cases of physician disability can be legitimate results of increased work pressures on doctors.

With changing work conditions in the 1990s, the financial benefits of having a documented disability under the terms of 1980s policies can outweigh the benefits of working as a physician. Claimants can receive a percentage of their gross monthly income, usually about 60 percent. Because disability benefits can be nontaxable, the dollar amount received often equals the claimant's net pay. Claimants with more than one policy can have a higher income out on claim than they earn on the job. At least one insurance executive has postulated that a retirement mentality has spread among physicians for many of the reasons discussed above.

Problems due to competition within the industry are not new. A July 1, 1930, deadline to eliminate the occupational definition of disability created a push in the late 1920s to write policies with "professional man's" clauses. The insurance industry's rush to include this clause, combined with poor underwriting practices and a failure to raise premiums, created serious losses in the 1930s.

Responses by the Insurance Industry

The insurance industry has responded to the recent increase in claims in a number of ways. Some companies have abandoned the disability marketplace com-

pletely. Others have changed the terms of existing policies, when possible. For example, at Paul Revere, there are now caps on specific dollar amounts to be collected per month, rather than allowing for a percentage-based calculation of monthly income. Companies are also changing the terms of newly issued policies to make them less liberal. These changes include: limitations on or elimination of own-occupation coverage, cost of living adjustments, and lifetime benefits; restricted availability of 30-day and 60-day elimination periods; reducing maximum benefits; and imposing stronger requirements for medical documentation of disability. In addition, insurance companies are selling policies less aggressively to physicians, attorneys, dentists, and other professionals. Companies are now focusing on middle-income markets as well as part-time workers and independent contractors who need portable individual disability plans. A wider policyholder base spreads the financial risk by not limiting a company's liability to one area.[9]

With psychiatric coverage, changes include limited benefits for mental and nervous disorders and for drug and alcohol abuse. Just as health insurance mental health benefits are now often subjected to limitations not applied to other illnesses,[10] several companies have begun to limit the benefit period for psychiatric disability claims to two years. In addition, some companies no longer approve coverage for potential customers who have been in psychotherapy within five years of submitting an application.[11] Policies eliminating coverage for customers who have been in therapy for the preceding five years have not yet been tested in courts. U.S. Courts of Appeals for the Sixth and Seventh Circuits have decided that employer-sponsored disability policies that have two-year limits on mental/nervous claims, but no similar restrictions on medical claims, did not violate the Americans with Disabilities Act (ADA) (*Parker v. Metropolitan Life,* 121 F.3d 1006 (6th Cir. 1997); *Equal Employment Opportunity Commission v. CNA Insurance Cos.*, 96 F.3d 1039 (7th Cir. 1996)).

Disability insurance companies have increased their scrutiny of current claims by having more face to face contact with professionals out on claim and by scheduling more follow-up evaluations. As is often the case with social disability insurance programs, these structural barriers can aggravate the process. IMEs and other actions the insurance company takes that question the professional's credibility can sometimes result in accentuation of the professional's disability behavior to "prove" the claim.[12]

Legal Issues in Private Disability Insurance

Many contested claims of disability end with a settlement between the company and the insured. For those cases that go to litigation, the wording of the policy will have a significant effect on the outcome. Courts may look to the terms of the policy for a definition of disability and to determine who bears the burden of proof and what must be shown to establish entitlement of benefits.[13] The claimant's disability typically does not have to be work related to qualify for benefits under the terms of private disability policies. As

some of the following examples illustrate, however, courts have latitude in how they interpret even seemingly explicit policy terms.

Own-Occupation Versus Any-Occupation A major issue is whether the policy insures against an inability to work in the professional's own occupation or an inability to work in any occupation. A policy that provides benefits only if the insured becomes unable to work in any occupation presumably would not cover a disabled physician who retained the capacity for nonprofessional employment. In the few cases that have directly addressed this issue, however, courts have awarded benefits to physicians unable to practice medicine. Own-occupation policies may still provide the added benefit of coverage for an inability to continue to practice in the insured person's subspecialty area.

In *Mutual Life Ins. Co. v. Frost*,[14] a 1947 First Circuit Court of Appeals case, an obstetrician suffered psychic trauma as a result of lawsuits and adverse publicity. Dr. Frost had life insurance policies that provided disability benefits only if it became "impossible for [him] to follow a gainful occupation." Despite the language of the policy, the court held that the physician had a total disability because of a mental breakdown that rendered him unable to practice medicine. The court stated: "If the speculation might be indulged in that perhaps he could sell pencils at street corners or serve as a gateman at a railroad crossing, this would not preclude the recovery of disability benefits under the policies. . . . There is nothing to show that. . . he would be able to. . . earn a livelihood in any way comparable to his former earnings in the profession for which he was trained."[14]

In *Continental Casualty Co. v. York*,[15] a 1965 Oklahoma Supreme Court case, a physician suffered a stroke that affected his abilities to understand what he read, to remember formerly familiar roads, to recall where articles were kept in his house, to remember recent events, to recognize people, and to carry on conversations. Although unable to work as a physician, he retained the capacity to work in nonprofessional occupations. His insurance policy provided coverage should an injury "wholly and continuously disable and prevent insured from engaging in each and every occupation or employment." Nevertheless, the court upheld the finding of disability by taking into account factors such as the professional's education, experience, and ability to follow another vocation, together with the dignity, permanence, and amount of income that can be earned from the substituted or alternative occupation.[15]

Total and Permanent Disability Although case law is limited, many courts have explained that "the concept of total disability need not be 100 percent deficient to justify a finding of total and permanent disability."[16] A doctor who loses professional skills need not be "absolutely helpless" before collecting disability benefits.[17] The physician impaired by a stroke in the case of *Continental Casualty Co. v. York*[15] had moments of mental agility and comprehension, but the court chose not to "place a literal construction on the interpretation of total disability." Instead, the court chose to follow a rule

endorsed by most other courts that total disability means "inability to do substantially all of the material acts necessary to the prosecution of the insured's business or occupation, in substantially his customary and usual manner."[15]

Although a finding of total disability may not require a complete inability to function, it is likely to require significant impairments. In *Clarkson v. New York Life Ins. Co.*,[18] a 1933 federal district court case, the court held that mere "neurotic tendencies" and "abnormal mental stress" would not qualify a claimant for disability. The court stated: "The term 'wholly and permanently disabled' is to be given a rational meaning—not strained in either direction. The term does not mean a state of absolute helplessness. Nor does the mere inability, at infrequent intervals, to perform some of the acts required in the conduct of a business or occupation constitute total disability."[18]

Similarly, in *Fidelity and Casualty Co. of New York v. Getzendanner*,[19] a case tried in 1900, the Supreme Court of Texas held that partial impairments might be insufficient to satisfy findings of total disability. In its reasoning the court stated, "There are infinite gradations in mental deterioration, and it is a matter of common knowledge that persons with some degree of cerebral disturbance may continue to prosecute with reasonable efficiency a business which requires the exercise of judgment and discretion."[19]

Preexisting Conditions Similar to the eggshell skull rule in tort cases, a preexisting vulnerability might actually help a claimant's credibility in proving the existence of a disability. In the previously cited case of *Mutual Life Ins. Co. v. Frost*,[14] the obstetrician had a personality disorder that rendered him "unable to cope" with lawsuits and adverse publicity brought on "by his own blunders . . . [and] psychopath[y]." In ruling that Dr. Frost's innate predisposition to psychological problems did not preclude disability benefits the court stated: "The company insured Dr. Frost in his then existing mental and physical condition, with all his latent frailties. . . . It is no matter that the impairment of mind or body may have been preexisting, if its effect in producing an occupational disability occurred after the policy was issued."

Illegal Activity Courts have been consistent in denying disability benefits based on illegal activity allegedly caused by mental impairments.[20–22] In *Massachusetts Mutual Life Ins. Co. v. Oulette*,[23] a 1992 Vermont Supreme Court case, an optometrist voluntarily surrendered his license to practice optometry and was imprisoned for lewd and lascivious conduct with a minor. Although pedophilia is not generally recognized as a mental illness, while in prison, Dr. Oulette sought disability benefits contending that he had a recognized mental disorder, pedophilia, that caused his behavior and rendered him totally disabled. The court noted, however, that Oulette could perform all the duties of optometry, and that "it is the legal consequences of his behavior that preclude the defendant from being able to work, not his mental illness." The court went on to state: "Imposing liability on disability insurance companies in cases like this would be contrary to the public interest in discouraging coverage for an

insured's own intentional criminal conduct."[23]

Some courts have also ruled in favor of the insurance company in a case in which claimants have not been convicted of a crime and have not voluntarily surrendered their licenses. In *Goomar v. Centennial Life Ins. Co.*,[24] a 1994 California federal district court case, Dr. Goomar lost his medical license after sexually molesting four female patients while he was in private medical practice in the state of New York. Dr. Goomar contended that visions of astral beings caused him to commit the molestations, and he sought to recover under his disability policies. The court ruled, however, that Dr. Goomar was improperly seeking to recover for a legal disability, not a factual disability: "Plaintiff's inability to practice his regular occupation is due to his license revocation rather than sickness or injury. Plaintiff continued to practice medicine until he was forced to stop when his license was revoked by the State of New York."[24] In *Damascus v. Provident Life and Accident Ins. Co.*,[25] a 1996 California case, Dr. Damascus, a dentist, was placed on five years' probation by the California Board of Dental Examiners after an accusation was filed in 1990 to have his license revoked for mental illness and grossly inappropriate care of patients. While on probation, he could work only under the supervision of another dentist and he was also required to seek treatment from a psychotherapist until the board deemed that no further treatment was necessary. After a second accusation of inappropriate care was filed in 1994, his license was revoked due to gross negligence and unprofessional conduct, but not on the ground of mental illness. The court held that Dr. Damascus did not show a mental disability that caused him to be totally disabled under his policy because he continued to work under the supervision of another dentist and because his license had not been revoked because of mental illness.[25]

Self-Inflicted Injury Coverage for self-inflicted injury is generally excluded under the terms of disability policies. In *Lynch v. Mutual Life Ins. Co.*,[26] a 1946 Pennsylvania superior court case, the physician appealed a decision denying disability benefits for chronic alcoholism because the condition was "self-inflicted." In supporting the trial judge's finding that chronic alcohol use was a "self-inflicted injury," the court noted: "Physicians were called as experts by both parties, and they differed widely and fundamentally upon the insured's condition and the general theme whether chronic alcoholism is a disease or a habit and a self-inflicted injury. . . . The medical testimony merely translates into scientific terms the age-old experience and observation of mankind. The act of drinking consummates the intention to experience the effect of drink. . . . Man drinks because he desires, intends, wills to experience the effects of the drink."[26]

Although further case law is limited regarding self-inflicted injury and alcohol/substance use disorders, recovery for self-inflicted injuries have been challenged in some courts with regard to attempted suicide and severe depression. In *Shelby County Health Care Corp. v. Whitten*,[27] a Tennessee appeals court

case, an insured appealed a lower court's summary judgment for an insurer. The appeals court held that a genuine issue of material fact still remained as to whether the policy's exclusion of "self-inflicted" injuries was applicable at the time of the attempted suicide or whether the policy's accidental injury may have been applicable instead. Because a self-inflicted injury might also be accidental if the insured did not foresee the possibility of injury, the court reasoned that the insured's severe depression may have impaired her ability to foresee the possibility of injury. Thus, the injuries might be accidental and therefore covered under the policy.

The Ultimate Issue If the insurance company contests the claim of disability and the case ends up in litigation, courts are likely to allow psychiatric expert witnesses to offer opinions on the ultimate issue (i.e., whether the claimant is disabled within the conditions of the policy). However, the fact-finder retains discretion on whether to endorse that opinion.

The Independent Medical Evaluation

In addition to changing the terms of the policies that they offer, disability insurance companies have also increased their scrutiny of psychiatric claims by scheduling more IMEs by forensic psychiatrists. The payment of substantial sums of money can depend, in part, on the outcome of the IME, especially when the insured is a physician or other professional. In cases that we have evaluated, monthly disability benefits have ranged from about $5,000 to $30,000 depending on predisability income and the number of policies involved. These benefits may be tax-free if the insured paid the policy premiums out-of-pocket. An IME that finds no disability jeopardizes continued benefits. It is not uncommon for claimants to approach these examinations cautiously, and some of them may make veiled or explicit threats against the examiner. Insurance companies also approach these evaluations cautiously, because if benefits are denied by the insurer and the decision is later overturned by the courts, punitive damages can be triple the initial payout.

Recommendations on Conducting the IME Interview At the start of the IME, the insured person (the insured) must be told the purpose of the evaluation, that the information obtained will be conveyed to the insurer, and that no doctor-patient relationship exists. Most insurers specify the content areas they want covered in the evaluation, and they usually request a full DSM-IV multiaxial diagnosis. In addition to the usual elements of a comprehensive psychiatric assessment, it is important to include the following information: the insured's current income, disability benefits, and policy terms; current symptoms and stressors; a description of the insured's typical day before and after the onset of disability; and, future plans and self-prognosis. It is essential to learn how the insured functioned up to the time of disability, what contributed to the disability, and what has changed in the insured's ability to function. Efforts at and responses to treatment, as well as efforts at returning to work during or after treatment, should be reviewed.

It is best to adopt a neutral and non-

confrontational approach to the clinical interview. If malingering is suspected, the most useful approach is to focus on discrepancies in the data rather than to become argumentative.

An electronic record of the interview may be helpful, either in the form of an audio- or videotape. This supplements note-taking by allowing the forensic examiner to go back and review key portions of the interview and to obtain verbatim quotes. In addition, this verbatim record can be helpful if the IME is challenged or if the case is further appealed or goes to trial. Recordings should be made only with the consent of the insurer and knowledge of the insured.

Sources of Information As with other forensic evaluations, using multiple sources of information helps in the establishment of diagnoses and in the assessment of functioning. Information from third parties can help corroborate the insured's self-report, increase the degree of certainty that the examiner has in the opinions offered, and bolster the examiner's credibility should the opinions be challenged. The insured may have valid reasons for attempting to withhold access to third-party information, but because of the seeming paucity of objective findings with many psychiatric disorders, insurance companies may be especially concerned about the potential to malinger illness.

The absence of third-party information proved to be important in the case of Dr. Goomar, the physician who claimed that visions of astral beings led him to sexually molest his patients. The court rejected the opinions of two psychiatric experts who apparently failed to gather information other than that provided by Dr. Goomar. The court stated that the two experts "claim that they can opine as to plaintiff's condition fourteen years ago based upon his self-report to them." The court rejected this testimony as "unsupported speculation."[24]

Case 1 Dr. A., a 50-year-old physician, had been on disability for a psychotic disorder for 18 months before the IME. He had about 20 separate policies paying a combined monthly benefit of about $31,000. He told the examiner that he had been hearing voices for most of his adult life and that the U.S. government had been using satellites to track him and control his behavior. Although he had never sought psychiatric treatment before filing for disability, he reported that he had expressed these beliefs and talked about his hallucinations for years to many people, all of whom had suggested that he seek treatment.

Within the first few months of filing for disability, Dr. A. self-referred to at least six psychiatrists. He volunteered to each of them that he had a "psychotic disorder" with "paranoia." He accepted prescriptions for antipsychotic medications, and he had each of the psychiatrists write letters supporting his disability claim.

Interviews with Dr. A.'s wife, primary care physicians, personal attorney, and former office staff revealed that he had never expressed bizarre beliefs, never reported hearing voices, and never appeared to be responding to hallucinations. Further inquires revealed that he had applied for all of his disability policies during a criminal investigation into over two

million dollars of fraudulent bills to medical insurance companies. He was eventually convicted of these crimes and sentenced to over four years in prison.

Case 2 Dr. B., a dentist, went out on disability for depression even though he had been suffering from depressive episodes for 25 years. Three years before the current evaluation, Dr. B. told the IME examiner that he took a period of mental disability in anticipation of changing jobs to work in the computer industry. For 25 years he had always dreaded going into work at his dental practice, constantly experienced dry heaves and shakiness, but was generally able to work. Although he mentioned periods of intense depression that prompted several inpatient hospitalizations, he did not discuss these periods extensively with the IME examiner. He mentioned a suicide attempt 15 years ago, but said that it was not medically serious.

A review of medical records revealed that Dr. B.'s one prior suicide attempt actually consisted of several deep stab wounds to the abdomen with a butcher knife and several pieces of sharp steel. The suicide attempt required surgery with an extensive medical hospitalization, followed by a six-month inpatient psychiatric hospitalization. Record reviews also revealed that Dr. B. had three inpatient psychiatric hospitalizations, including treatment with electroconvulsive therapy, during his previous period of disability. Both of these episodes of depression, as well as other episodes of depression, were correlated mainly with Dr. B.'s inability to handle periodic increases in work load at his dental practice.

In this case, a review of medical records showed depressive episodes that were much more serious than the claimant discussed with the IME examiner. The records helped to confirm that Dr. B.'s job stress worsened his diathesis toward relapse. Without using sources of information other than the claimant, the IME examiner may have mistakenly assumed that Dr. B.'s claim was due mostly to a personal dislike for dentistry.

Psychological Testing Psychological testing can help in the functional and diagnostic assessment and add to the credibility of the IME. Authentic deficits can support the validity of self-reported impairments, and discrepancies and scatter on formal testing can support opinions regarding malingering. At a minimum, it is often helpful to include an MMPI-2. The IME report can include a summary of the relevant portions of the test results, with the full psychological testing report appended.

Case 3 A well-educated claimant presented with profound deficits, including disorientation and an inability to recite the alphabet, during psychological testing. These findings were inconsistent with other observations of his functioning, such as driving himself to the appointment.

Case 4 Mr. C., a probate attorney, filed for partial disability under an own-occupation policy attesting that chronic fatigue syndrome and sleep apnea interfered with his concentration and memory, and that his fatigue worsened as the day progressed, forcing him to stop working every day around 3 p.m. On psychological testing, Mr. C. had lower than ex-

pected performance based on his intellectual functioning on tasks requiring sustained attention with high cognitive processing demands. These subtle deficits supported Mr. C.'s complaint of mild difficulties while performing the most demanding aspects of his work. Although he continued to work, the terms of his own-occupation policy made him eligible to receive partial disability benefits with only a minor cognitive impairment.

Surveillance In some cases, surveillance can provide crucial information that cannot otherwise be obtained. The diagnosis of some potentially disabling psychiatric disorders relies primarily on a person's self-report of the symptoms. Treatment providers may routinely accept the validity of these self-reports without seeking independent confirmation. For the IME examiner, however, surveillance, along with other sources of information, can help in the assessment of the claimant's credibility. Some companies may obtain surveillance before they make the referral for a psychiatric IME.

Case 5 Mr. D., a 50-year-old professional, went on disability after he allegedly experienced a sudden and severe onset of panic attacks and agoraphobia. He began collecting $10,000 a month in disability benefits. His corporation, which apparently had been having financial problems, went bankrupt two months after he left. Mr. D. saw a therapist for counseling and a psychiatrist for medications, both of whom supported his claim for total disability. Up to the time of the IME, he complained of continuing severe and incapacitating symptoms including: intense anxiety resulting in an inability to be around or interact with people, or even to talk on the telephone; total lack of concentration; and severe memory problems.

The insurance company retained a private investigation agency. The investigation revealed that since going on disability Mr. D. had taken numerous trips in the United States and abroad. The investigators followed Mr. D. on a two-week trip abroad where they videotaped him sightseeing in crowded places and engaging in lengthy and intensive negotiations concerning undeclared business activities.

Conclusions

Increasing claims by physicians and other professionals have led disability insurers to change their underwriting practices and to increase their scrutiny of claimants. Psychiatric claims, usually for depression, constitute about 18 percent of total payouts and often last longer than claims based on nonpsychiatric disorders. An awareness of the legal and clinical issues involved in these cases can guide the forensic psychiatrist who conducts an IME. A comprehensive evaluation may help to distinguish claimants who feign or exaggerate impairments from those with truly disabling conditions.

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