Assessing Adverse Outcomes and Learning Needs in Canadian Psychiatric Independent Medical Examinations

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Despite the importance of independent medical examinations (IMEs), there is virtually no literature on the risks to the IME assessor nor the learning needs of psychiatrists in this area. To address this deficit, a retrospective chart review of nearly 38,000 cases from the Canadian Medical Protective Association (CMPA) identified 108 files involving complaints or legal actions against psychiatrists performing IMEs. Most complaints identified by the CMPA were to regulatory bodies, including biased opinion, inadequate assessment, inappropriately relying on a requester's information without independent evaluation, nonadherence to regulatory body policies, cursory documentation lacking relevant details, and communication breakdowns. A survey by the Canadian Academy of Psychiatry and the Law (CAPL) and the Canadian Psychiatric Association (CPA) had 306 Canadian psychiatrist respondents. About 37 percent of psychiatrists completing IMEs reported medico-legal consequences, including complaints to regulatory authorities. Only 40 percent of those doing IMEs and 20 percent of all psychiatrists had formal training in doing IMEs. The studies confirm that despite a low but important risk of medico-legal consequences, many psychiatrists performing IMEs do not have formalized training. Using the new CAPL *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing* is a step to reduce the risk of such evaluations.

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Independent medical evaluations (IMEs) are assessments conducted on individuals strictly for the purpose of a third-party process and not for the provision of health care. IMEs can include a file review (e.g., reviewing medical records, reports, collateral information) and examination (e.g., physical, psychological) of the individual to provide crucial opinions at the interface of law and psychiatry. IMEs can include criminal responsibility (Not Guilty by Reason of Insanity) and Fitness to Stand Trial (Competence to Stand Trial) in criminal courts; violence and sexual offending risk assessments; disability, malpractice, and psychological harm in civil courts; practice concerns for professional regulators;

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and fitness to work or accommodation for employers. In some jurisdictions, the term IME might only include disability evaluations, but in Canada and for this review, the term IME encompasses this wide variety of independent assessments. IMEs are also called Forensic Mental Health Assessments (FMHAs)[1] or third-party assessments.

Clinical encounters differ from IMEs in many ways. Clinical encounters focus on a patient and must fulfill a fiduciary duty to act in the patient's best interests, while IMEs focus on an evaluee to provide an evaluation and opinion that is fair, objective, nonpartisan, and directed at specific legal questions, and that may not be in the best interest of the evaluee.[2–4] IME assessors usually have extensive and relevant collateral information for each case and are expected to come to legally defensible opinions. They require unique training and expertise to consider specialized topics such as external gain and malingering by the evaluee. Although a case may not go before a court, most have a legal context, and the outcome could ultimately be appealed to the courts.

The specialized nature of IMEs brings unique risks. Although IMEs should be unbiased, some studies have shown there is a risk of unconscious bias with a large effect size toward the retaining party.[5] IME assessors may unknowingly receive biased and incomplete records from the retaining party,[6] distorting the assessment. Some individuals performing IMEs may not have sufficient training and experience in legal matters and the role of the expert. For example, a review into pediatric forensic pathology in Ontario found that a physician gave unsubstantiated opinions on child abuse, which were used to convict a number of accused individuals.[7,8]

Psychiatric IMEs provide essential information allowing decision-makers to understand complex mental health concerns. They are intended as an unbiased resource for stakeholders. Despite their importance, at times IMEs are viewed negatively. The courts[9,10] and society[11,12] have raised concerns about conflict of interest and unethical behavior, such as the assessor being paid to provide a specific nonindependent opinion.[13–15] Some describe IMEs as simply producing a high-priced business product.[16] Such concerns have been expressed historically even back to the 19th century;[17] however, they may be overstated with many reporting a positive experience with IMEs.[18,19]

Separate from these concerns and a focus of the current article, IME assessors may themselves face legal consequences. This could include complaints to provincial, state, and territorial regulatory bodies (e.g., Colleges of Physicians and Surgeons) and civil suits. Although regulatory bodies might publish individual investigations of complaints involving IMEs, they do not make data available about the number, type, and outcome of complaints and there is almost no information on IME liability for psychiatry. Regardless, nonpsychiatry publications show growing liability for IME assessors.[20,21]

Gold[22] has published one of the only reviews of some of the legal risks in psychiatric IMEs, illustrated through American case law. She noted that courts may find an IME assessor liable if there was injury during the examination, if significant findings were not disclosed in a reasonable manner, or if confidentiality was breeched. Courts may also find liability for negligence claims, defamation, invasion of privacy, breach of contract, perjury, and other intentional torts, or there may be complaints to regulatory agencies.

The risks related to bias, lack of expertise to perform IMEs, and negative perceptions of IMEs, as well as the legal risk to assessors highlight the importance of training in conducting expert, unbiased, and objective IMEs, and of training in navigating the judicial process and testimony. All Canadian and American forensic subspecialty training programs require teaching and experience in IMEs, but IMEs are often performed by general psychiatrists without formal fellowship training in forensics. For general psychiatrists in Canada and the United States, there is a lack of formalized training in forensic topics, including IMEs.[23–27] Despite the importance of these subjects for psychiatry, there has never been a published review of legal actions involving psychiatric IMEs in Canada or abroad, nor of the learning needs for psychiatrists in these areas.

Given this deficit in the literature, the current two-part study aims to gain a better understanding of psychiatric adverse outcomes in IMEs and psychiatrists' perceived training needs in this area. The first part is an evaluation of the adverse outcomes data from the Canadian Medical Protective Association (CMPA). The second part is an analysis of Canadian psychiatrists' self-report data from a Canadian Psychiatric Association (CPA) IME learning-needs survey.

Methods

CMPA Data from 2016 to 2020

The Canadian Medical Protective Association (CMPA) provides medico-legal support for over 105,000 physician members, representing over 95 percent of Canadian physicians. A retrospective, descriptive study was conducted using data from the CMPA's repository of medico-legal cases, which includes civil legal matters and complaints against physicians to provincial and territorial regulatory authorities (i.e., Colleges). The Advarra Institutional Review Board[28] provided ethics approval for this part of the study.

Experienced in-house medical analysts from the CMPA reviewed all civil legal actions and complaints to regulatory authorities closed by the CMPA between January 1, 2016 and December 31, 2020. Cases involving a psychiatrist and flagged as IMEs were included while class action legal cases were excluded. There may have been more than one allegation per case.

Presenting conditions and complainant allegations were extracted. In cases where there was peer expert criticism of the psychiatrist's performance of an IME, the CMPA's contributing factor framework[29] was applied to identify themes. A sample of individual cases were reviewed to identify illustrative examples.

CPA Member Survey in March 2022

In part two of the study, members of the Canadian Academy of Psychiatry and the Law (CAPL) conducted a learning-needs survey in collaboration with the Canadian Psychiatric Association (CPA). This was in preparation for developing an accredited self-assessment program (SAP) based on the series of 10 guidelines, *The Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing.*[30] These guidelines are intended for general psychiatrists, forensic psychiatrists, and other clinicians conducting IMEs. Ethics approval was not required as it was a learning needs assessment.[31]

In developing the survey, in addition to a literature search, the training requirements for psychiatry and forensic psychiatry from the Royal College of Physicians and Surgeons of Canada (RCPSC), the websites of medical regulatory bodies across Canada, and preliminary data from the CMPA were reviewed. This review revealed that despite the importance placed on IMEs by the RCPSC, regulatory bodies, and the CMPA, there is limited teaching about IMEs in general psychiatry and there are significant perceived deficits in training in medico-legal topics.[23–27,32]

A short online survey in English and French was developed by the CPA to assess general psychiatrists' experiences with and training in conducting IMEs. Over one month in March 2022, 1,507 psychiatrists who were members of the CPA and who consented to receipt of electronic communication were surveyed. This represents about 30.8 percent of psychiatrists in Canada.[33] The survey included two screening questions: "Do you, or have you, conducted IMEs?" and "Have you had specific training in conducting IMEs, report writing, and/or testifying?" Based on responses to these two questions, the respondents were asked up to six further multiple-choice questions. In addition, all participants were asked how many years they had been in practice and were invited to provide written comments. A total of 306 psychiatrists responded (20%).

Results

CMPA Data from 2016 to 2020

As seen in Fig.1, of the nearly 38,000 medico-legal cases the CMPA closed between 2016 and 2020, only 3.3 percent of cases involved psychiatrists and only .9 percent involved any type of physician doing IMEs. Of these physician IMEs, there were 108 cases involving a psychiatrist performing an IME, which represented nine percent of all cases involving psychiatrists, and 32 percent of all IME cases.

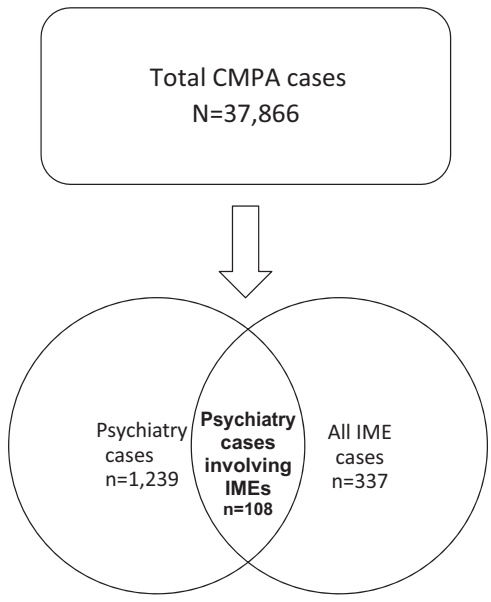

Figure 1. CMPA legal cases involving IMEs and psychiatry.

Table 1 IMEs Involving Psychiatry from 2016 to 2020

Total CMPA Cases = 37,866 Total IMEs = 108	
Physician profile (75 psychiatrists involved)	81% were men (61/75) 65% were in practice >20 years (49/75) 69% had only 1 case in data set (52/75)
Type of legal concern	88% regulatory body complaints (95/108) 12% Civil legal action (13/108)
Province	56% Ontario (60/108) 25% Quebec (27/108) 19% Other (21/108)

As summarized in Table 1, 75 psychiatrists were involved in the 108 psychiatric IME cases; some cases involved more than one physician and some psychiatrists were named in more than one case. Most psychiatrists were male (81%) and had been in practice for more than 20 years (65%). While most were involved in only one medico-legal case related to IMEs during this period (69%), nearly a third had more than one case. Most of the cases (88%) were regulatory body complaints, with the remaining 12 percent being civil legal actions. Complaints were primarily from Canada's two largest provinces, Ontario (56%) and Quebec (25%). The most common allegations were deficient clinical assessment, deficiencies in documentation, and a perception the psychiatrist's manner was unprofessional.

As seen in Table 2, 39 percent of cases (43 out of 108) were reviewed by a peer expert. The contributing factors with peer experts' comments are included. Some of the cases had multiple types of contributing factors and not all cases had comments. Experts criticized the psychiatrists for biased opinion, inadequate assessment, inappropriately relying on a requester's information without independent evaluation, nonadherence to regulatory body policies, cursory documentation that lacked relevant detail, and communication breakdowns between the psychiatrist and evaluee.

CPA Member Survey in March 2022

Table 3 outlines the responses of the 306 respondents in the CPA survey. Respondents were generally quite experienced, with an average time in practice of 23.8 years (median 22 years). A majority (60%) had never conducted an IME. Among the 39 percent who have conducted IMEs, about half (54%) complete five or less per year and 45 percent complete more than five annually. Many of those who have conducted IMEs reported a medico-legal problem arising from the IME, such as regulatory body complaints or litigation (37%).

Of the 306 respondents, 80 percent said they have not had specific training in conducting IMEs, report writing, or testifying; this included about 60 percent of those actually doing IMEs. Of the 42 respondents reporting an adverse outcome, such as a regulatory body complaint or litigation, half reported

Table 2 Peer Expert Contributing Factors and Comments on Psychiatric IME Cases ($n = 43$)

Contributing Factor	Peer Expert Comments
Professionalism and conduct concerns ($n = 20$)	Psychiatrist IME opinions were biased, not approached objectively Information gathered for IME not done in collaboration with other healthcare providers (e.g. staff of group home)
Clinical decision-making ($n = 13$) (less than thorough clinical assessment)	Failure to complete a mental status exam or include differential diagnoses Inappropriate reliance on information from the employer's investigative report, which had not been independently verified Deficient medical history (e.g. current level of physical activities) and limited details regarding clinical observations
Procedural violations ($n < 10$)[a]	Nonadherence to the legislative framework and regulatory body policies governing IMEs, including required notation of physician's qualifications and experience, and a list of the documents reviewed
Deficient documentation ($n = 21$)	Failure to explain or document thought processes or how the conclusions were reached Sparse, sometimes illegible documentation, which lacked details
Communication breakdowns with evaluees ($n = 14$)	Consent not obtained to disclose health information to a third party Not alerting evaluee about diagnostic findings that would likely require further treatment (e.g., serious mental illness) Not ensuring communication is respectful regarding cultural sensitivity Not explaining the reasons for the IME and the physician's role in the process
Office problems ($n < 10$)[a]	Delay in sending a report caused ineligibility for disability benefits

[a] For confidentiality purposes, exact numbers are not reported when there are fewer than 10 cases.

Table 3 IME Experience And Perceived Learning Needs among Canadian Psychiatrists ($n = 306$)

Time in Practice	Mean = 23.8 years (Median = 22 years)
Have conducted an IME	115/306 (39%)
1 to 2 per year	50/115 (43%)
3 to 5 per year	13/115 (11%)
More than 5 per year	52/115 (42%)
Had adverse outcome	42/115 (37%)
Had specific training	46/115 (40%)
Had specific training	55/306 (19%)
During residency	26/55 (47%)
Post-residency	47/55 (85%)
Online course/literature	39/55 (71%)
Took courses	43/55 (78%)
Training with supervision	33/55 (60%)
Other source	11/55 (20%)
Want more training	21/55 (38%)
No specific training	231/306 (80%)
Want more training	146/231 (63%)

having previous training and half reported no previous training.

Among the less than 20 percent who have had specific training, about half reported receiving training during residency, with larger percentages reporting training following residency, including online courses, reviewing the literature, and taking courses. Sources of training included the Certified Independent Medical Examiner (CIME) certification and other workshops from the American Board of Independent Medical Examiners (ABIME), training from the Canadian Society of Medical Evaluators (CSME), expert witness training from SEAK Inc., mentoring from trusted colleagues, subspecialty training in forensic psychiatry, workshops from provincial licensing authorities, and the diploma microprogram (Diplômes d'études supérieures spécialisées (DESS)) from the University of Montréal. Of those with specific training in IMEs, about 38 percent said they needed more training. Approximately 63 percent of those without any training in IMEs said they would like more training, although the current study did not clarify their perceived barriers to such training.

Some respondents included comments, such as they would welcome the opportunity for training in conducting IMEs in residency training and in continuing professional development. In addition to IMEs, educational interest was expressed in subjects of disability, disability tax credit, and accident injury. Observations included that "too many wade into the IME arena" without proper skills and training, and it would be very important to develop courses and standards for competent practice in this area. The importance and difficulty of ensuring IMEs are not biased to the retainer was highlighted. Some who support the need for more training were not in favor of "strict or formal requirements" for IMEs. Others indicated that clinical resources should not be diverted for the purpose of conducting IMEs.

Discussion

The review of CMPA cases shows that while psychiatry cases form a minority (3.3%) of all CMPA medico-legal cases for the period reviewed, as do physician IMEs (.9%), complaints about psychiatric IMEs account for nearly 10 percent of all psychiatric cases and a third of all physician IMEs. The current study is not able to clarify the reasons why IMEs by psychiatrists result in such a large portion of the total complaints compared with other specialties. It may be that psychiatrists simply perform a larger number of IMEs and psychiatric IMEs are no more risky than other IMEs.

The CPA survey data show that 37 percent of psychiatrists performing IMEs reported facing medico-legal problems, such as regulatory body complaints or litigation. This supports the findings of the CMPA data and, as highlighted by Gold,[22] there are real risks for psychiatrists performing IMEs.

Table 2 highlights potential areas of improvement for psychiatric experts performing IMEs. These included biased opinion, inadequate assessment, inappropriately relying on a requester's information without independent evaluation, nonadherence to regulatory body policies, cursory documentation lacking relevant details, and communication breakdowns.

A large percentage of respondents of the CPA survey conduct IMEs. Despite the legal risks, few respondents have specific training in IMEs, including those actively performing IMEs. Half of those noting legal fallout said they had specific training in IMEs, equal to those reporting no training. This might suggest that training did not alter outcomes for such complaints, but the study was not designed to evaluate the effect of training on adverse outcomes. The quality of the training could not be evaluated. As we noted, there is almost no specific training in psychiatric IMEs other than formalized fellowship training in forensic psychiatry. Further, it may be that those with specific training take on more challenging cases or do more assessments, increasing the relative risk of such fallout.

As we have previously discussed, the courts and society have raised concerns about the conduct of IMEs. Assessors are often perceived as biased. The courts at times reject independent opinions based on perceived bias. The Goudge Inquiry[7] underscored the serious risks of insufficient training and encouraged mandatory training. In addition, there are legal risks to assessors performing IMEs. Recognizing these concerns, the RCPSC has since recognized both Forensic Psychiatry and Forensic Pathology as subspecialties and have outlined some of the training and experiences needed for IMEs.

Many individuals conducting IMEs likely have not or would not pursue forensic subspecialty training. At the same time, the CPA survey revealed that many individuals do not have specific IME training, and they did not receive training in residency, confirming previous findings.[23–27] This highlights a need for training and ongoing professional development focused on IMEs tailored to meet the learning needs of physicians performing these assessments.

In Canada and the United States, there are resources and available training for physicians performing IMEs. Provincially, and in most states, many of the regulatory bodies offer comprehensive policies and guidelines for IME assessors which aim to improve IME quality. At minimum, assessors must adhere to these regulatory body policies and guidelines relating to IMEs,[4] notably a factor highlighted in the current results. Other resources include guidance from provincial, state, and national medical organizations such as the Canadian Medical Association and the CMPA. Groups specifically developed for IME assessors also provide training and resources, including the Canadian Society of Medical Evaluators (CSME) and the American Board of Independent Medical Examiners (ABIME). Unfortunately, none of these are specific to psychiatry or forensic psychiatry.

While there is significant training in criminal and civil IMEs in the forensic psychiatry subspecialty training programs in Canada, there had been no specific Canadian guidelines until the recent *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing*.[30] These include the General Principles that are applicable to any IME. They are linked to nine specific guidelines, three in the criminal domain (fitness to stand trial, criminal responsibility, and dangerous offender assessments), two which could be either in the criminal or civil domains (violence risk assessment, and sexual behavior and risk of sexual offending assessments), and four in the civil domain (assessments of disability, fitness to work, personal injury, and professional misconduct and malpractice). A *Self-Reflective Checklist for Third Party Assessments* is also associated with the guidelines.

Table 4 IME Risk Mitigation Recommendations

Pursue ongoing professional development and training in IMEs
Review the CAPL *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing*
Complete self-assessments, and where appropriate and permitted, seek peer review of your IMEs
Attend training at conferences and by IME organizations
Adhere to regulatory and legislative requirements in your jurisdiction
Consult IME resources with your regulatory body, medical organizations and the CMPA
Only undertake IMEs for which you are qualified
Obtain informed consent, including ensuring the evaluee understands the reasons and expectations for the IME
Perform objective, unbiased, and thorough assessments of IME evaluees
Use precise language to document the assessment and how an evaluee's clinical presentation led to conclusions

Given the lack of training availablefor IMEs, it is hoped that forensic psychiatrists will take a lead on increasing the availability and quality of training in this area. Recently, the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing* have been presented at a Canadian Psychiatric Association meeting with a specific IME training session in response to the CPA Needs Survey. They have also been presented at other international meetings.

The current study did not examine the approach used by those doing IMEs (e.g., whether standardized techniques or validated instruments were used). The Guidelines and further workshops would be a resource to address these topics.

The goal of conducting IMEs is to provide assessments and opinions that are fair, objective, and nonpartisan. These assessments can be an invaluable resource to those requesting such assessment. There are risks associated with such assessments, however. To reduce the risks, the authors suggest several mitigation strategies based on analysis of the medicolegal cases, review of the literature, and the authors' clinical experience and training (see Table 4). This includes ongoing professional development and training, and the need to adhere to local regulatory and legislative requirements.

Limitations

While the data presented provide useful insights, there are some limitations for consideration. The CMPA medico-legal cases likely represent only a portion of IME concerns, as not all would be reported or involve the CMPA. Nonphysician concerns are not captured, and physicians may elect to navigate complaints without CMPA assistance. The cases could also be influenced by recall bias, and analyses of these cases are prone to hindsight bias and outcome bias.

Similar to the CMPA review, the CPA data have some important limitations. The sample was limited to those CPA members consenting to electronic communication and responding to the survey. While 20 percent response is typical, there may be a bias in responders more interested in the topic. As noted, the study was not designed to evaluate barriers to obtaining further training in IMEs, nor whether more training actually decreases medico-legal risk. Future evaluation in these areas is warranted.

Conclusions

While IMEs are an important tool in many legal processes, there are several potential risks inherent with IMEs. In particular, there is a potential legal risk for assessors. The current studies are the first large-scale study of psychiatric IMEs in Canada and likely have applicability for American psychiatrists and those abroad. These results confirm that while such legal problems account for a small portion of medico-legal concerns in CMPA cases, psychiatric IMEs comprise a relatively large portion of IME complaints. The areas of concern are consistent with those seen in the literature.

The results of the studies further confirm that there continues to be a perceived unmet need in IME training, with an absence of formal training in a high proportion of those completing IMEs. To address the risks and limited training, IME assessors are encouraged to pursue ongoing training. Several resources are available, including the CAPL guidelines.[30] There are also a number of other risk mitigation strategies available.

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