

Disability Guideline, Role Conflicts, and Treatment Records

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The AAPL Practice Guidelines for the Forensic Evaluation of Psychiatric Disability reminds treating psychiatrists as well as forensic examiners of the potential for role conflicts and of numerous factors related to handling of treatment records. This commentary suggests ways of more completely avoiding role conflicts, including those related to payment, and elaborates on implementation of requirements of the HIPAA Privacy Rules applicable to independent examination by third parties.

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I welcome the AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability.¹ This comprehensive document will advance the state of the art in disability-related forensic examinations. However, I offer the following commentary on the potential for role conflicts and concerns surrounding health information.

Strasburger *et al.*² and Greenberg and Shuman³ have identified the potential for problems that can arise out of conflicts between the roles of treating clinician and forensic examiner. The Guideline¹ reminds us that these conflicts can arise, not only in litigation and marital dissolution cases, but also when third parties ask clinicians to make determinations related to work, such as fitness for duty, accommodation, workers' compensation, and disability, correctly emphasizing the potential for ethics-related and practical pitfalls. The American Academy of Psychiatry and the Law Ethics Guidelines for the Practice of Forensic Psychiatry states:

In situations when the dual role is required or unavoidable (such as Workers' Compensation, disability evaluations, civil commitment, or guardianship hearings), sensitivity to differences between clinical and legal obligations remains important [Ref. 4].

However, I believe we can completely and ethically eliminate such conflicts, to avoid negative impact on treatment relationships and to avoid providing determinations of dubious value and validity to employers and other third parties.

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Roles Defined

Let me define the various roles addressed in this commentary more clearly. The primary role of clinician requires little further elaboration. The clinician owes a duty to the patient to diagnose and treat illness, keeping the patient's health considerations paramount. In exchange the patient pays for the service. (This payment arrangement may not hold in some treatment settings, such as those in which the clinician is employed by a clinic.) Potentially conflicting roles include obtaining financial compensation for the patient (disability benefits, time loss compensation), assisting the patient's employer with employment or accommodation decisions (fitness for duty), and assisting workers' compensation programs with coverage decisions (causality, barrier to recovery, reimbursement for treatment). What is good for the patient's mental health, not what is good for the employer or payer, should prevail.

Employers and disability payers have historically exploited two characteristics of the treatment relationship. (1) Physicians often prefer to sign a form that appears innocuous at first glance rather than take valuable time to assess the implications fully, and (2) clinicians often want to comply with apparently reasonable requests for help put forward by the patient and by doing so have supported a practice that subordinates treatment concerns to financial concerns and expedience, and may lead to situations in which, for example, a patient may seek psychiatric consultation under the guise of obtaining treatment when the real agenda is to obtain financial benefits and avoid work.

When the clinician's assumption of a conflicting role compromises treatment, as it usually does, the treatment interests of the patient should always take precedence. The fact that a practice is common does not make it ethical or proper. The treating physician who provides an assessment that his or her patient cannot work may be communicating conflicting messages, to the detriment of the treatment. The patient may interpret such a message as a pronouncement by the clinician that attempts to recover from the mental disorder may be hopeless. "You cannot work" may not always be consistent with "I can help you." Conflict can arise when a physician believes that the patient will not be able to pay his or her bill for treatment unless the patient qualifies for disability compensation. This situation can lead to a conspiracy in which the physician supports the patient's claim of disability, resulting in a perpetuated pretense of treatment, exacerbating the omnipresent conflict of interest inherent in fee-for-service medicine: if the patient recovers, the clinician loses income. What is good for the patient's mental health, not the physician's pocketbook, should prevail.

Suppose, for example, that a patient claims persecution by the employer or a coworker but the clinician believes psychosis plays a role. Despite the apparent mental disorder, the clinician believes the patient is performing adequately at work and is benefiting from the structure and activity of working. Communication with the employer, even when authorized by the patient, may threaten the treatment alliance, thus undermining recovery.

Clinicians with both forensic and clinical practices may face the added pitfall of treating patients who work for an employer who is also a forensic client. In this situation the clinician may feel compelled to provide a determination that will lead to more forensic cases from that client-employer. What is good for the patient's mental health, not the forensic practice, should prevail.

Payment

In some of these nonclinical roles, the third party may offer to compensate the clinician specifically for performing an assessment. Acceptance of such a payment increases the potential for role conflict to the extent that it leads to allegiance to the payer.

When confronted with the question of whether a treating psychiatrist can ethically assume the role of obtaining financial compensation for a patient, the

APA Ethics Committee held that the treating psychiatrist can ethically provide this service or not and can ethically charge or waive a fee for the service.

Our responsibility to patients (Section 8) and our need to maintain consideration for patients and their circumstances (Section 2, Annotation 6) suggest that such assistance, while not obligatory, is appropriate, and may be advisable. The contractual arrangement between patient and psychiatrist (Section 2, Annotation 5) should establish in advance whether a charge may be made for such service. When this has been done, charging a fee is not inherently unethical. However, when the time required is not unduly burdensome, the ethical psychiatrist may elect to waive a fee [Personal communication from Linda Hughes, the Director of APA's Office of Ethics and District Branch and State Association Relations, on October 14, 2008, in response to a request for an opinion by the Ethics Committee].

By saying, "anything goes" the committee seems to shrink from pronouncing a widespread practice unethical and to accord admittedly very real financial constraints more influence than they deserve. Accepting even a small symbolic payment from the patient, while refusing payment from the third party for such a determination, can preserve the professional relationship and eliminate ambiguity as to who is the client. What is good for the patient's mental health, not the patient's pocketbook, should prevail.

In litigation, clinicians can avoid role conflict while complying with the wishes of the courts by limiting testimony to facts about patient and treatment while declining to offer opinions. The courts lack authority to force a clinician to form or express an opinion. Although employers and Social Security Disability Income (SSDI) expect and may be said to "require" determinations regarding disability or fitness for duty, clinicians can and probably should refuse to provide them. Third parties always have the option of engaging the services of an independent examiner to make needed determinations. Instead of providing determinations, clinicians can offer, if authorized by the patient, to provide treatment records. These records may include documentation of recommendations to the patient: instead of writing, "In my opinion the patient is able (or unable) to return to work," write "I am recommending return to work (or medical leave)." This preserves the treating physician's role as advisor to the patient, not the employer, and makes it clear that the clinician is assisting the patient, not the employer.

In workers' compensation cases, reimbursement for treatment may hinge on the clinician's opinion as

to whether an industrial event caused the illness. Advancing such an opinion may be self-serving in that it leads to pay for the clinician. When a worker injures a body part in machinery at work, causality is clear, but it is not so clear when a mental disorder follows an industrial event. In treating most mental disorders with no potential industrial cause, approach to treatment does not depend on determination of causality. We do not know what causes most mental disorders, nor does an established procedure or body of knowledge exist for determining causality (with the exception of cases involving a traumatic or organic agent). In particular, when several events or circumstances compete as candidates, there is no method for choosing the causal event from among them. Until we elucidate a mechanism by which a mental illness arises, such a methodology is likely to elude us, and opining on causality is disingenuous. Some industrial insurance programs reimburse for treatment of disorders identified as impediments to recovery from a physical injury even absent evidence of causality. To avoid providing an opinion about causality, the clinician can decline to schedule an initial evaluation until provided with written documentation that the claim has already been accepted as reimbursable, perhaps based on the results of evaluation by a forensic examiner.

The Guideline¹ recommends establishing in advance how clinicians should address requests for work-related determinations about patients. Clinicians can accomplish this by including relevant written policy in patient contract or office policy statements that can be published on a practice Web site, and by attempting to identify during the initial telephone contact patients whose agenda is to obtain disability.

The Guideline notes that when a state medical board requests forensic evaluation of possible physician impairment, the “costs of such evaluation are generally borne by the physician examinee rather than the state.” Allegiance may again follow payment, such that the forensic examiner feels a duty to the subject who is paying instead of to the client. In such cases, the examiner should instead insist on a contract with, and payment by, the state. The state can require reimbursement from the physician examinee. What is good for the physician’s patients or the client, in this case the medical board, not the possibly impaired physician, should prevail.

Medical Records, HIPAA, and the Privacy Rule

The Guideline states, “. . . a treating psychiatrist should advise the patient, to the extent possible, of the consequences of releasing medical records” (Ref. 1, p S32). Clinicians should recognize, however, and perhaps communicate to the patient, that an insurance agent, attorney, or other professional may be more capable of assessing such consequences.

The Guideline recommends listing of records and other material relied on in making a determination. Forensic examiners often include direct quotations from treatment records in the report of evaluation. This use of records raises the interesting question of whether such inclusion might constitute re-release of medical records, and whether re-release is prohibited or required by law.

Requirements of HIPAA and the Privacy Rule applicable to handling of health information, as noted in the Guideline, may apply to aspects of evaluations related to work and disability. HIPAA and the Privacy Rule apply only to covered entities. The determination of whether a clinician is a covered entity under HIPAA may hinge simply on whether the clinician bills electronically for medical services or supplies.⁵ In theory at least, HIPAA and the Privacy Rule do not apply to the clinician who is not a covered entity.

Other law and ethics-based considerations, however, come close to replicating many of the requirements of the Privacy Rule.⁶ Perhaps the most significant exception in the context of forensic work is the requirement of the Privacy Rule that the examiner must accord the examinee access to the records and report resulting from the examination, except under certain circumstances.⁷ The Privacy Rule allows the examiner legally to deny access when there is reasonable likelihood of harm as determined by the examiner. This denial of access, however, is reviewable by another professional, and the examiner must notify the examinee of the denial in writing within 30 days of the request. The examiner who denies access must specify another professional to review the denial, and if that professional determines that reasonable likelihood of harm does not exist, the record must be provided in its entirety.

Regardless of the outcome of the review, the examiner may withhold only those parts of the record deemed likely to result in harm if viewed by the

subject. The remainder of the record must be provided.

There may be little experience to guide us in conforming to this law, which does not specify who might be the victim of such danger. The Guideline rightly states that the examiner should be “concerned about personal safety.” Thus, assessed risk of danger to the examiner may allow denial of access of that portion of the record that might lead to danger if released. There is likewise little experience to guide the reviewer of the denial who, since this activity involves assessment of dangerousness, may wish to draw on standards for other such risk assessments. This determination weighs the physical safety of the subject, the examiner, or other parties against access to a piece of information to which the examinee is likely to obtain access through other means, such as his or her attorney, employer, or treatment provider. Nonetheless, such a determination should probably err on the side of safety. There may be no standard for the level of risk acceptable. Any risk at all may justify denial of access.

If access to the record leads to harm after a reviewer fails to uphold denial of access, it is conceivable that the reviewer may be held liable. The reviewer may therefore justifiably demand to examine the examinee to meet professional standards for determinations of dangerousness. Because the original examiner (or the examiner’s client) may bear the cost, however, such reviews are more likely to be perfunctory, at least until there is a bad outcome or until such a case is litigated. Forensic examiners may want to add appropriate provisions for payment for review to the language of their contracts.

Summaries

The Guideline addresses use of summaries provided in lieu of actual treatment records to obtain background information. Although the Guideline states that examiners “should not rely solely on summaries” (Ref. 1, p S13), there is a subsequent statement that “A cogent, readable summary of a patient’s record is more likely to assist in making the claim than are handwritten chart notes” (Ref. 1, p S32). This statement creates a potential ambiguity in the recommendations, depending on whether one is fulfilling the clinical or forensic examiner role. It is probably always true that the patient’s privacy is at stake and that treatment records can contain private information; however, no examiner should ever trust

a clinician to determine what is relevant to a forensic determination in lieu of providing access to the complete record. When a clinician decides unilaterally to provide a summary in lieu of complete records, the examiner should consider whether the provider might have intentionally omitted information critical to the determination.

Preparation of a summary can take longer than copying records, sometimes leading to costly delays, for example, in returning the subject to work. It may help the client, especially an employer unaccustomed to ordering forensic examinations, to provide a form letter to be given to treatment providers that insists on access to the complete record, possibly outlining the examiner’s understanding of applicable statutes and case law.

New Medical Record Technologies

New information technologies offer different challenges. Redaction of paper records by blacking out selected text clearly showed that information was omitted. With the advent of the electronic medical record (EMR), however, comes a capability for what might be called stealth redaction where the records provided contain no evidence that other information was omitted. Clinicians using such software applications may require separate specific requests for records of, for example, electronic mail communications with the patient. The records provided may contain no reference to the omission. Some EMR software allows printing or electronic transmission of what to all appearances is a complete medical record, but which in fact omits reference to selected “sensitive” data such as records of diagnosis or treatment of psychiatric disorders, substance use disorders, or sexually transmitted diseases, again with no indication that information was omitted.

The Guideline addresses numerous conventional sources of information regularly tapped in support of forensic determinations, but the evolution of the Internet in particular offers new sources and raises new questions. Blogs (Web logs), social networking sites, and other Web sites can contain potentially relevant information, in text, image, or video, about examinees or their treatment providers. In the future we must decide whether we should make sure to investigate such sources or avoid them.

Conclusions

When third parties request determinations, clinicians can preserve the sanctity of the clinical relationship by limiting their roles to diagnosis and treatment and by accepting payment only from the patient, while forensic examiners should accept payment only from the client.

Implementation of the HIPAA Privacy Rule pertaining to medical records, including forensic reports, continues to evolve. Even judicious use of treatment summaries in support of disability assessments carries risks and should be avoided.

References

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