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INHERENT CONFLICTS of INTEREST
In the CALIFORNIA WORKERS COMPENSATION SYSTEM

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Various terms can be used to describe the California Workers' Compensation System. Logical, Effective, Efficient – are nowhere on that list. There have been multiple significant changes to California Workers Compensation Law over the past two decades – 1993; 2003, and most recently, 2006 (changes which became effective between July, 2006 and January 1, 2007). The most recent changes were for the most part devised by a group of MBA's, selected by Governor Schwarzenegger, and the confirmed by the Legislature. Motivations for the changes were political and economic, under the rationale that high Workers Compensation premiums were "driving businesses out of California". Understanding of clinical issues, the well-being of patients, and ethical quandaries regarding positions physicians were placed into were, by all indications, of little or no concern. [*In my personal conversations with an assistant to the Governor, I asked if it was being considered that the overall impact of these changes would like increase the overall costs of medical care (when considering that patients would still require treatment outside of the Workers Compensation system, even if he "compensability threshold for certification of industrially-related injuries was raised – and I was told, "We are only considering Workers Compensation right now." I also note that I sent letters to all (bipartisan) members of the legislative sub-committee assigned with devising the new laws, volunteering, based upon my 18 years working within the comp system, to provide information that would be useful in making the system more efficient and cost-effective without diminishing the level of medical care being provided to patients. The only responses I received were requests for campaign donations*.] Changes in the law were effected to (theoretically) acutely decrease the "bottom line" cost of the system, with little regard to the practical, clinical, or even long-term financial consequences. Certain issues regarding the revised laws remain controversial, the subject of different legal opinions, with definitive interpretation still awaiting judicial review.

As the system now stands, in my opinion, physicians are placed into positions of inherent conflicts of interest in several different areas of the medical-legal evaluation and treatment.

Basic Medical-Legal Issues

At multiple points in the processing of a claim, various medical-legal issues must be addressed:

Causation

- Is there a diagnosable injury?
    - This is a clinical determination.
    - If there is no finding of a diagnosable injury, there is no compensable claim.
- If there is a diagnosable injury, it must be considered if the injury is "predominantly" (> 51%) due to "objective workplace stressors"? (The threshold drops to "substantial", i.e., > approximately 35%, in cases involving violence in the workplace; there are other technicalities which impact the "threshold", such as whether the claim was filed within the first 30 days of employment, or after notice of termination, in which case the injury must be deemed to have been the result of "sudden and extraordinary" events. However, those technical issues are not specifically relevant to the discussion of conflicts of interest for the physician, as the germane point involves when a physician is required to pass judgment regarding Causation, rather than the specific thresholds for determination of an industrially-related injury.)
    - This is a clinical determination, to be made based upon the medical/psychiatric evaluation of the mechanism of injury.
        - If the legal threshold is not met, the claim is not compensable.
- If a diagnosable injury meets the threshold of compensability vis-à-vis having been caused by "objective workplace stressors", it then must be determined if those "objective workplace stressors" were "substantially" due to "lawful, good-faith personnel actions", i.e., legal administrative actions such as normal performance expectations, appropriate disciplinary actions, simple personality conflicts, etc.

- This, technically, is not a medical decision, but a determination to be made by a Trier of Fact. However, on a practical basis, the referring Claims Examiner expects the evaluating physician to provide at least a provisional opinion, while deferring "definitive" opinion to the appropriate Trier of Fact.

- If the "stresses" were due to lawful, good-faith personnel actions, the claim is not compensable; if the "stresses" fell outside of that rubric, the claim is compensable.

Temporary Disability Status

- Is the patient capable of performing his or her full usual and customary duties, is the patient Temporarily Totally Disabled from performing any activities in the open workplace, or is the patient Temporarily Partially Disabled, requiring some restrictions and modification of their job duties in order to be medically released to return to work?

    - This is a clinical determination.

Permanent Disability

- Once a patient who has an accepted industrially-related injury reaches the point of maximal medical improvement (and is technically deemed "Permanent and Stationary"), is there any residual "ratable" impairment in their ability to function in the open workplace, due to psychiatric symptomatology?

    - This is a clinical determination, currently based on GAF scores. For cases filed prior to 1997, a "Work Function Impairment Form" was filled out, which rated the patient on eight "axes" of practical functioning. The final "percentage of disability" arrived at through each of these methods may differ, in that the GAF is more sensitive to *pathology and symptomatology* rather than "pure" impairment *per se* (that is, the presence of symptomatology, even without documented practical impairment, may result in a "ratable" impairment or an increased "percentage of impairment"), while the Work Function Impairment Form focuses only on areas of practical impairment, with symptomatology used only to justify the ratings, but symptomatology not of itself being a "ratable" factor.

- If there is permanent impairment, is any of that impairment Apportionable to non-industrial factors, such as pre-existing psychopathology, or symptomatology present due to concurrent non-industrial life stressors?

    - This is basically a clinical determination, but may require the input of a Trier of Fact vis-à-vis issues of the objective reality of workplace or external life circumstances.

    - Prior to changes in the law, Apportionment could only be made to pre-existing verified *impairment*; currently, Apportion must consider *Causation*, including pre-existing *pathology*, even if the pre-existing pathology was not previously causing any practical impairment.

- Is the patient capable of returning to their usual and customary duties, full duty or with modifications; or will they require retraining/vocational rehabilitation (and thus be deemed a "Qualified Injured Worker" for vocational rehabilitation purposes)?

    - This conclusion is based upon the clinical determination of necessary restrictions or limitations, and the practical availability of sufficient "reasonable accommodations" by the employer.

The Initial Evaluation

Typically when a patient files a claim of industrially-related psychiatric injury, whether or not they have been evaluated or treated by a personal physician, they are referred for evaluation by a primary care Occupational Medicine physician. In psychiatric cases, that physician will usually perform a very superficial evaluation – essentially taking a history of a few lines, evaluating any concurrent physical symptomatology, and check for danger to self or others – and then deferring a full evaluation to "appropriate experts", i.e., a mental health professional. However, even at that stage, the primary care physician is asked for a preliminary opinion regarding Causation. Although there typically is not a significant conflict of interest in that regard in that the evaluation is being performed for medical-legal reasons and there is no treatment relationship established regarding any mental health treatment, the physician is placed in a difficult and possibly unethical position of presenting an opinion regarding Causation based upon a superficial and incomplete database. Often, this determination is "deferred" to a mental health professional, but that does not change the fact that the physician is asked to perform a duty of questionable validity (in all but the most obvious cases).

Once a patient is referred to a mental health professional, it is expected that a comprehensive evaluation will be performed. Technically, that evaluation should provide

1) diagnoses; 2) determinations of acute impairment/disability; 3) treatment recommendations and 4) whether or not any diagnosable injury is "predominantly" due to "objective workplace stressors". However, although by law determinations regarding the issue of whether an injury was "substantially caused by lawful, good-faith personnel actions" should be deferred to a Trier of Fact, in almost all cases, it is specifically requested by the referring adjusters that the physician provide at least a provisional opinion in that regard.

At the same time, under the criteria established by current California Workers' Compensation Law, the insurance carrier has 90 days to evaluate a claim, and make a determination whether or not the claim is compensable. During those 90 days, the carrier must provide recommended treatment (as long as the cost of treatment does not exceed $10,000, which obviously is not an issue in psychiatric claims, and is more applicable to physical and particularly orthopedic/neurological injuries). At any point during those 90 days, the carrier can accept the claim, in which case treatment continues on an industrial basis; or the carrier can deny the claim, in which case the carrier still must pay for any treatment rendered to that point in time, but authorization for any future treatment is immediately discontinued. Further, it is established by the law that the physician who has performed the initial evaluation must immediately implement any mental health treatment he or she has recommended.

Thus, the evaluating physician is placed in a position of conflict of interest, in that immediately upon addressing medical-legal issues; he or she must then establish a therapeutic treatment contact. This is not particularly problematic when it is obvious that the claim is compensable, but this is very problematic when the circumstances do not allow the evaluating physician to provide a definitive determination, such as when the claim involves circumstances (e.g. allegations of harassment, or a "hostile work environment") which must be definitively evaluated by a Trier of Fact; or when the patient has a pre-existing psychiatric history, but there is insufficient objective data available (i.e., no prior medical records yet available for review) to be able to reasonably determine whether the current symptoms are "predominantly" industrially-related.

Specific conflicts of interest arise in that:

- The physician establishes a therapeutic treatment alliance, but may be called upon to issue an opinion regarding Causation upon receipt of additional medical records, employment records or witness statements to review – and that opinion may be used to immediately deny authorization for any further treatment.

- If the carrier denies the compensability of the claim during the 90 day period of time, the physician has the options of:

- Continuing the treatment on a non-industrial basis – although it is rare that the patient is willing to do so, has the financial ability to do so, or that the patient's medical insurance (often an HMO or PPO) will cover the treatment costs through the physician who is already providing treatment.

- Continue the treatment *pro bono.*

- Immediately discontinue the treatment, leaving the patient with an unresolved and problematic termination, and often having been prescribed psychotropic medications, with no provisions for continued prescription or monitoring of psychopharmacological intervention other than perhaps through a community clinic, if that is possible.

Most often, the treatment ends precipitously, with the patient still suffering from symptomatology of the unresolved initial injury, exacerbated by the inappropriately fractured and unresolved treatment relationship, and in increased danger by having been prescribed psychotropic medications, with no provision for follow, continuation, or safely monitored discontinuation.

Thus, inherent to California Workers Compensation Law, the patient is often placed in the position of being iatrogenically injured, and the physician is placed in the position of being ethically compromised regarding conflicts of interest in both providing treatment and providing a forensic opinion regarding Causation, as well as being ethically compromised and possibly in a position of liability regarding a clinically inappropriate termination of treatment vis-à-vis both psychotherapeutic and psychopharmacological intervention issues.

Issues Regarding Disability Status

Arguably, determining the patient's state of disability may be considered a "therapeutic issue" to be discussed and addressed within the context of the treatment relationship, but at times this issue also causes a conflict of interest between the demands of the medical-legal system, and the best interests of the clinical treatment of the patient. Making this determination involves evaluating specific symptomatology and related impairment, as well as frequently taking into account complex complicating issues of somatoform symptomatology; intentional, unconscious or histrionic symptom magnification, and/or acting out regressively in the service of avoidant or dependent characterological pathology. Practically, the demand by the medical-legal system for immediate physician determination of disability issues does not allow for therapeutic exploration or "working through" of complicating factors, and to that extent, the treating physician is placed in the conflicted position of having to provide a medical-legal determination of disability status without the opportunity to effectively address and explore the related dynamics, emotional conflicts, and/or behavioral acting out within the

context of the therapy; and without the opportunity to provide any effective treatment intervention prior to providing a legal determination.

However, even more problematic is determination of Permanent Disability Status. While typically, the patient will eventually be referred for an independent medical evaluation (in California Workers Compensation terms, an "Agreed Medical Examination" or a "Qualified Medical Examination") for a definitive determination of disability ratings, the treating physician is still called upon to provide an opinion and to document ratings. The GAF rating given, as well as the "degree of Apportionment" provided, translate into specific determinations of the ultimate financial settlement the patient will receive. **Obviously, placing the treating physician in the position of providing even a provisional determination which can impact the financial compensation to the patient creates an ethical problem. Impacting the patient's financial gain certainly falls well outside of the therapeutic treatment relationship, and may either iatrogenically disrupt that relationship, or iatrogenically reinforce (or make it impossible to objectively explore) dysfunctional issues related to dependency and/or narcissistic entitlement.**

Finally, serious conflicts between indicated therapeutic interventions and required forensic requirements can occur when the treating physician is required to determine if the patient is capable of returning to his or her usual and customary duties. While determination of the ability to return to work can be rather straightforward when evaluating issues such as orthopedic impairment, the questions are much more complicated on a psychiatric basis. On one hand, a patient may perceive themselves as suffering from a "disability", and ma have a strong desire not to return to work, based upon issues which the physician may perceive and a question of personal preference or choice. That is, the lack of motivation on the part of the patient not to return to work, which may or may not be very reasonable and understandable, may be clinically deemed not to be the result of any specific psychiatric symptomatology or impairment. That is, a patient may suffer emotional distress, or even overt affective symptomatology, if feeling "pressured" to return to a position they do not *like*, do not *want*, or perhaps *fear* (e.g., returning to positions which involve inherent dangers, repetitive exposure to trauma; or positions which involve inherent repetitive interpersonal conflicts, such working in a law enforcement or correctional environment, work as an EMT, working in a hospice, working as a collections agent, etc.) – but the patient's motivation not to return to work does not necessary imply that there is a psychiatric disorder which would prevent the patient from returning to work, <u>if motivated to do so</u>. (Certainly, every person who might be fearful of becoming a law enforcement officer, or unwilling to accept the abuse inherent to doing collection work, is not "psychiatrically disabled" from that vocation, nor should they be eligible for "disability" benefits in that regard.) On the other hand, a person's vocation is often an important aspect of his or her identity, and even after a significant injury or trauma, a person may be unwilling to leave a profession to which he or she has been devoted, and which have become an important contributing factor to identity and self-esteem. For example, I have worked with patients who were

law enforcement officers, or hospice workers, whom I fully believed no longer had the emotional stability to return to those professions, yet the patient was in serious denial, insisting that with additional time or treatment he or she would yet recover and be able return to work in their previous positions – even when it was discussed with the patient that clinically, the possibility of returning to the previous job duties appeared at best remote, and certainly inadvisable. While working through such issues of identity and self-esteem are part-and-parcel of the therapeutic process, under the requirements of California Workers Compensation law, that physicians provide specific opinions on these issues as soon as the patient is deemed to have reached a point of "maximal medical improvement" vis-à-vis their overt symptomatology, which forces the treating physician to render an opinion which may be contrary to the position of the patient, without sufficient time to explore and address the issue sufficiently within the context of the therapy.

In summary, even physicians who fastidiously attempt to maintain appropriate boundaries, commitment to providing the best possible clinical services, and avoidance of any breach of ethics or conflicts of interest are placed in the position where the legal demands of the California Workers Compensation system place the physician in the position of having to make problematic compromises, or completely withdraw from participation in the system (a system in which there are already too few physicians participating to be able to adequately serve the number of patients in need of treatment). Currently, there is no resolution apparent on the horizon, and in fact, the situation is worsening due to problematic intervention by third-party "Utilization Review" evaluators (an issue which deserves separate consideration).