Medical Evaluation of Work-related Illness: Evaluations by a Treating Occupational Medicine Specialist and by Independent Medical Examiners Compared

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Treating physicians' and independent medical examiners' (IMEs') opinions were compared to identify differences of opinion and to develop a basis for understanding the differences. Twenty-three patients of an occupational health center (OHC) who had been examined by an IME were studied. OHC and IME opinions regarding diagnosis, work-relatedness, treatment recommendations, and disability assessment were categorized by degree of agreement. There was agreement on all four issues for only one patient. Opinions were most divergent with regard to disability assessment and least divergent with regard to diagnosis. Disagreement was unidirectional: the IMEs made fewer diagnoses, deemed fewer illnesses work-related, made fewer treatment recommendations, and assessed lower levels of disability than the OHC examiners. The results suggest that differences in opinion between the OHC and IMEs are due to differences in perspective, rather than skill or training. Key words: occupational medicine; independent medical examinations; workers' compensation.

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When a worker is diagnosed with a work-related illness a workers' compensation claim may be filed. In the United States, workers' compensation systems have been developed by individual states. These state run systems cover the vast majority of U.S. workers, with the exception of federal employees and a relatively small number of other workers. Employers either purchase workers' compensation or choose to self-insure. In some states insurance is purchased from private insurance companies, while others require insurance to be purchased from a state fund. A few states, including New York, where this study was conducted, maintain mixed systems allowing employers to purchase insurance from either a private insurer or a state fund. Workers' compensation boards, which are state agencies, process workers' compensation cases and make judgments in contested cases.

State-run workers’ compensation systems allow the Workers’ Compensation insurance carrier and/or employer responsible for paying the claim to require the injured worker to undergo medical evaluation by a physician of the carrier/employer’s choosing. The “independent medical examiner” (IME) chosen is asked for an opinion regarding any or all of four major issues: diagnosis; work-relatedness of the diagnosis; extent and duration of disability; and treatment. In New York IMEs are certified by the Workers’ Compensation Board. Certification appears to be essentially automatic as long as the physician has a license to practice in the state and is board-certified in a specialty recognized by the American Board of Medical Specialties.1

The term “independent” applied to carrier/employer-contracted examinations suggests these examinations are unbiased, specifically in comparison with the opinions of the treating physician. Those touting the virtues of IMEs argue that severing the link between doctor and patient eliminates the role of the physician as patient advocate and the constraints that role imposes on the objectivity of the physician. In contrast, the IME establishes no relationship with the patient and is, consequently, not influenced in his or her opinions by anything other than the facts gathered in the evaluation.  

The view of IMEs as objective and unbiased is not universally shared. Critics point out that while the IME is independent of the patient, he or she is connected financially to the carrier and/or employer, creating a fundamental conflict of interest. Consequently, any bias removed by eliminating the doctor–patient relationship is replaced by biases imposed by the IMEs' need to maintain good relationships with carriers/employers.4,5,6

In response to this criticism, IME proponents assert that properly trained IMEs adhere to a rigorous evalu-
ation method that renders bias unimportant. If the IME carries out the evaluation using the correct method it will be objective and valid. In addition, trained IMEs are aware of, and are expected to abide by, a code of conduct that prohibits them from giving opinions influenced by carrier or employer interests rather than the facts.²

The authors of this paper are associated with an academically based, publicly funded occupational health center. Worker patients are evaluated at the center almost exclusively for occupational illnesses, including work-related musculoskeletal disorders of the arms, neck, and upper back. Individuals with low back pain or acute injuries are rarely seen at the center. Many of the individuals seen have chronic and complicated health problems. Patients are referred from a variety of sources, including physicians, unions, attorneys, and employers, and via self-referral.

Not surprisingly, many of the worker patients seen at the center apply for workers’ compensation benefits and are required to undergo an examination by an IME. Frequently the opinion of the IME conflicts with aspects of the center’s treating physician’s opinion. As a consequence of this experience, this study was developed to:

1. compare and contrast the opinions of the treating physician with those of the IME on the issues of diagnosis, work-relatedness, treatment, and disability;
2. identify patterns or common themes among the differences of opinion;
3. assess the potential impact of these differences on the workers’ compensation benefits received by injured workers; and
4. develop potential explanations for the differences identified.

METHODS

Charts for analysis were randomly chosen from those of new patients evaluated at the occupational health center (OHC) between January 1999 and July 2000. Every fifth chart was chosen and utilized if the report of an independent medical examination obtained for evaluation of a workers’ compensation claim was present. Two patients initially evaluated prior to 1999 were also included, as they had undergone relatively recent examinations by IMEs. Through this process 27 IME reports on 23 patients were collected. The number of examinations was greater than the number of patients because three patients were examined more than once.

Utilizing a standardized protocol, each of three clinicians reviewed approximately a third of the IME’s reports and patient charts, obtaining and recording the desired information set. Two of the clinicians (an MD and a nurse practitioner) practice at the OHC and specialize in occupational medicine. The third clinician is a family practitioner who does not practice at the OHC. General data collected included: type of illness by organ system; name and specialty of the IME; payer of the IME; and lengths of time between illness onset and examinations by the OHC examiner and the IME. The payer of the IME was identified by the letterhead of the IME report and /or the person to whom the report was addressed. Reports on the physician’s office letterhead presumed the payer was the insurance carrier or administrator to whom the report was addressed. IME reports were also submitted on the letterheads of companies that contract with insurance carriers to provide IMEs. In those cases it was presumed that the physician performing the IME was paid by the contracting company rather than the insurance carrier.

Specific data were obtained from the IME report and the OHC chart regarding the following four issues: diagnosis; work-relatedness of the diagnoses; treatment recommendations; and disability assessment. Every diagnosis made by the OHC examiners and the IMEs was recorded. Whether the diagnosis was deemed work-related by either the OHC examiner or the IME was also recorded. Treatment recommendations specifically reviewed included: medications; surgery; physical therapy; workplace restrictions; workplace modifications; recommendations to go out of work; and other. Disability assessment reviewed: the presence or absence of disability; whether the disability was total or partial; whether the disability was temporary or permanent; and whether the disability should be apportioned between work-related and non–work-related causes. If differences between the OHC examiner and the IME were identified in any of the areas reviewed, the reviewing clinician provided a summary description of the differences. After the data were collected, the forms used for reporting the data were reviewed and a determination of whether there was agreement, partial agreement, or disagreement between the OHC examiner and the IME on each of the major issues was made. In addition, the clinician assessed the likely impact of the IME’s opinion on the worker patient’s access to medical benefits and level of compensated wage replacement, relative to the opinion of the OHC examiner. The compiled data were tabulated and analyzed.

RESULTS

Patient Demographics

Of the 23 patients, approximately two thirds were women and all but one described themselves as Caucasian. More than 60% of the patients were between 36 and 50 years old. These characteristics are shown in Table 1.

Patient industry and occupation are illustrated in Figures 1 and 2. Seventy percent of the patients worked in either a manufacturing or a service setting, the numbers being fairly evenly split between the two. Among occupations, skilled and unskilled blue-collar jobs predominated.
Characteristics of the Independent Medical Examiners

The IMEs were 14 different physicians. However, two physicians, both pulmonary specialists, performed 15 of the examinations, one performing nine and the other performing six. The other 12 physicians performed one examination each. Specialties among the 12 included orthopedics (4), neurosurgery (2), internal medicine (2), geriatrics (1), dermatology (1), and podiatry (1). The specialty of one IME could not be determined from his report. The IMEs' examinations were performed between 1996 and 2000 in the following distribution: 1996 (1); 1997 (1); 1998 (3); 1999 (17); 2000 (5).

The IMEs were paid directly by the Workers’ Compensation Insurance Carrier or self insured employer’s administrator five times (19%). Of the rest of the IMEs, 22 (81%), were paid by contractors. The amounts IMEs received in payment were unknown. OHC evaluations were billed to the Workers’ Compensation Insurance Carrier at rates determined by the New York State Workers’ Compensation Board.

Characteristics of Patient Visits

All but two patients were evaluated at least twice, and almost two thirds of the patients were seen six or more times at the OHC, as can be seen from the data in Figure 3. All but one patient were evaluated once by any individual IME. Three patients were examined twice by different IMEs and one patient was examined twice by the same IME.

The lengths of time between onset of illness and examination are shown in Figure 3 for both OHC and IME examinations. Whereas 48% of the patients evaluated by the OHC were seen within six months of the onset of illness, and 78% were seen within one year of onset, only 23% of the IMEs’ examinations were performed within the first six months after onset and 44% were performed less than a year after onset.

Figure 3 also illustrates the timing of the OHC and IME examinations relative to each other. Of the 27 IME examinations, the patient had been evaluated at the OHC first 23 (85%) times. When the patient was evaluated first at the OHC, the IME examination was conducted at least six months later in 13 cases (56%) and more than a year later in 7 cases (30%). In three of the four cases in which the IME evaluated the patient first, the OHC evaluated the patient within six months.

<table>
<thead>
<tr>
<th>TABLE 1. Demographics of the Study Population (n = 23)</th>
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<tr>
<td><strong>No. of Patients</strong></td>
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<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<td>Age</td>
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<tr>
<td>20–25 years</td>
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<td>36–50 years</td>
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<td>51–65 years</td>
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<tr>
<td>&gt; 65 years</td>
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<tr>
<td>Ethnicity</td>
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<tr>
<td>White</td>
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<tr>
<td>Hispanic</td>
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</table>

Figure 1—Numbers and percentages of patients in the study by industry.
**Diagnosis**

The types of problems experienced by the patients included respiratory (16), musculoskeletal (7), neurologic (4), dermatologic (3), allergic (1), and generalized or systemic (2) illnesses. The number of illness types was greater than the number of patients because a number of patients experienced illnesses that included more than one category.

In the overwhelming majority of examinations, 25 of 27, there was at least partial agreement between the OHC examiner and the IME on diagnosis. For 12 examinations there was complete agreement and for two examinations there was complete disagreement regarding diagnosis. Specific diagnoses and the degree of agreement/disagreement are shown in Chart 1.

The examinations among which there was agreement included asthma (5 examinations), contact dermatitis (2 examinations), rhinosinusitis, plantar keratosis, pleural thickening, headaches, general toxic/allergic reaction, carpal tunnel syndrome, shoulder impingement, and a laceration. One of the patients with asthma was examined three times by two different IMEs.

Among the examinations where there was partial agreement, the agreed-upon diagnoses included: asthma (3 examinations), shoulder impingement, acute intoxication (2 examinations), rhinosinusitis, upper airway irritation (2 examinations), pleural plaques, myofascial pain syndrome (2 examinations), frozen shoulder (2 examinations), low back pain, cervical radiculopathy, asbestos exposure, cervico/thoracic strain, and cervical degenerative joint disease. Disagreement among these cases included: additional diagnoses made by the OHC examiners, whether symptoms/illness was ongoing, and the nature of ongoing symptoms/illness. In 12 of the 13 examinations the OHC examiners made additional diagnoses not made by the IMEs. For two examinations the additional diagnosis was depression secondary to the other illnesses diagnosed or to the psychosocial circumstances of the illnesses. For 11 examinations the additional diagnoses made by the OHC examiners were related to the diagnosis upon which there was agreement. For example, for one examination there was agreement on the diagnosis of shoulder impingement, with the OHC examiner adding the diagnoses of rotator cuff tear and cervico/thoracic strain. Another example is where there was agreement on the diagnoses of rhinosinusitis and upper airway irritation, but only the OHC examiner diagnosed asthma.

On two examinations the IME did not recognize ongoing symptoms or illness identified by the OHC examiner. One individual was diagnosed as having asthma by both the OHC examiner and the IME, with only the OHC examiner recognizing the ongoing nature of the illness. In another case both the OHC examiner and IME agreed the patient had been exposed to asbestos and other dust during the demolition of an old building. However, the IME did not recognize ongoing symptoms diagnosed as industrial bronchitis and upper airway irritation by the OHC examiner.

On two other examinations the IME and the OHC examiner agreed there were ongoing symptoms, but disagreed about the nature of the symptoms. On these examinations the OHC examiner identified the ongoing illnesses as sequelae of the workplace exposure, whereas the IME attributed the symptoms to psychological causes (“symptom magnification,” “disease fixation ideation syndrome”).

The OHC examiner and the IME disagreed completely on diagnosis for two cases. On both of these examinations the OHC examiner diagnosed an ongoing respiratory ailment, whereas the IME diagnosed a psychological illness (“symptom magnification”).

**Work-relatedness**

Agreements/disagreements between the OHC examiners and the IMEs with regard to work-relatedness are
summarized in Chart 1. For nine examinations (33%) there was complete agreement, for eight examinations (30%), partial agreement, and for ten examinations (37%), disagreement.

Chart 1 also illustrates how agreements/disagreements on work relatedness were distributed by agreement/disagreement about diagnosis. Among the 12 examinations with agreement on diagnosis, there were nine (75%) with complete agreement about work-relatedness and three (25%) with disagreement. The IME was of the opinion that the condition was pre-existing for two of the examinations where there was disagreement with the OHC examiner.

Among the 13 examinations with partial agreement on diagnosis there were eight (62%) with partial agreement and five (38%) with disagreement on work-relatedness. Partial agreement about work-relatedness generally reflects the fact described above in the diagnosis section, that the OHC examiners identified more diagnoses than the IMEs. Diagnoses made only by the OHC could only be judged work-related by the OHC examiners. In four cases the IMEs and OHC examiners agreed that an acute workplace exposure had been responsible for causing symptoms. However in two of
those cases the IME believed the illness had resolved whereas the OHC examiner recognized chronic sequelae. In two additional cases the IME was of the opinion that any residual illness was of psychological rather than workplace origin.

For the two cases for which there was disagreement on diagnosis there was also disagreement concerning work relatedness. In both of these cases the OHC examiner identified a workplace exposure responsible for ongoing symptoms, while the IME diagnosed psychological illness unrelated to work.

**Treatment Recommendations**

As shown in Table 2 the OHC examiners and the IMEs agreed on treatment recommendations in five examinations (18%). There was partial agreement in 11 examinations (41%) and disagreement in an additional 11 examinations (41%).

Of the five examinations for which there was agreement on treatment recommendations, three included only recommendations for medication, and included recommendations for work restrictions, and two included no recommendation.

**Disability Assessment**

Table 3 illustrates agreements/disagreements between the OHC examiners and the IMEs assessing disability. There was agreement on extent of disability in only one case, that of a patient with contact dermatitis. The OHC examiner and the IME partially agreed on disability in eight cases (30%) and disagreed in 18 cases (66%).

In 12 of the 26 examinations with disputed disability assessments (46%) the OHC examiners deemed the patients partially disabled and the IMEs determined no disability. The OHC examiners assessed nine patients...
(35%) as totally disabled, whereas the IMEs assessed no disability. In the remaining five cases (19%) the OHC examiners determined the patients were totally disabled whereas the IMEs assessed partial disability.

A review of Table 3 reveals a number of common bases for disputes over disability. In four cases the IMEs agreed the patients should avoid certain exposures (including an inability to return to the job where they became ill) but determined no disability to be present. In four additional cases the IMEs determined no or a lesser level of disability because abnormalities were not evident on examination or testing at the time of examination. The underlying reasoning in all eight of these cases is a definition of disability that requires “objective” abnormal findings at the time of the IME’s examination.

Among the nine patients deemed totally disabled by the OHC examiner and not disabled by the IME, four were recognized as disabled by the IME but the disability was deemed a consequence of non–work-related causes. In an additional three cases the IME was of the opinion that the patient’s illness was psychological and resulted in no disability.

Action by the employer (failure to accommodate, termination) was considered relevant by the OHC examiner, but not the IME, in determining disability in four cases. The IME’s opinion that there might have been a temporary disability following an acute exposure, but no ongoing illness or disability, contrasted with the OHC examiner’s assessment that illness and disability were an ongoing issue in three cases. Other reasons for discrepancies between OHC examiners’ and IMEs’ disability determinations included: non-recognition by the IME of conditions diagnosed by the OHC examiner, nonrecognition by the IME of the need to avoid future exposure, and (in one case) no disability assessment mentioned (or apparently performed) by the IME. In one case of a finger laceration, the OHC examiner and the IME came to different conclusions regarding disability on the basis of discrepant physical examination findings and different interpretations of the criteria used by the state Workers’ Compensation Board to determine a scheduled loss of use.

**Potential Effects of Disagreements on Patients**

For all but one of the patients included in the study, the potential impact of the IME’s opinion would be to limit workers’ compensation benefits. Medical benefits would be limited for 17 cases by IMEs’ opinions narrowing the number of diagnoses, disputing the work-relatedness of diagnoses, and disputing the need for treatment. In 25 cases lost wage compensation would have been reduced by the IME’s assessment of disability. In one case the IME’s opinion would have reduced a scheduled loss-of-use award. In no case would the

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**TABLE 2. Comparison of OHC Examiners’ and IMEs’ Treatment Recommendations**

<table>
<thead>
<tr>
<th>No. (%) Examinations</th>
<th>Nature of OHC and IME Discrepancy</th>
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<tbody>
<tr>
<td>Agreement 5 (18%)</td>
<td>No discrepancy</td>
</tr>
<tr>
<td>Partial agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Different medical treatment (1 patient)</td>
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<tr>
<td></td>
<td>OHC more medical treatment (5 patients)</td>
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<td></td>
<td>OHC work restrictions/ job modifications (4 patients)</td>
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<td></td>
<td>OHC out of work (6 patients)</td>
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<tr>
<td>Disagreement 11 (41%)</td>
<td>OHC more medical treatment (7 patients)</td>
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<td></td>
<td>OHC work restrictions/ job modifications (7 patients)</td>
</tr>
<tr>
<td></td>
<td>OHC out of work (7 patients)</td>
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</table>

**TABLE 3. Comparison of OHC Examiners’ and IMEs’ Disability Assessments**

<table>
<thead>
<tr>
<th>No. (%) of Examinations</th>
<th>Nature of OHC and IME Discrepancy</th>
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<tbody>
<tr>
<td>Agreement 1 (4%)</td>
<td>Not applicable</td>
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<tr>
<td>Partial agreement 8 (30%)</td>
<td>IME recommended limiting exposures but assessed no disability (4 patients)</td>
</tr>
<tr>
<td></td>
<td>IME found no disability because physical examination and/or testing was normal (4 patients)</td>
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<tr>
<td></td>
<td>IME said disability was not work-related (4 patients)</td>
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<tr>
<td></td>
<td>IME found no disability because he or she felt illness was psychological in origin (3 patients)</td>
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<tr>
<td>Disagreement 18 (66%)</td>
<td>IME did not recognize employer’s failure to accommodate as cause of disability (4 patients)</td>
</tr>
<tr>
<td></td>
<td>IME recognized only temporary disability (3 patients)</td>
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<tr>
<td></td>
<td>IME did not recognize diagnosis deemed disabling by OHC</td>
</tr>
<tr>
<td></td>
<td>IME did not agree with OHC physical examination findings and interpretation of State Worker’s Compensation Guidelines</td>
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</table>
IME’s opinion have increased the benefits awarded based upon the OHC examiner’s evaluation. When there is a dispute between the OHC examiner and the IME, final determination of the nature and extent of workers’ compensation benefits is established through negotiated settlement or judgment by the Workers’ Compensation Board.

**DISCUSSION**

The extent of disagreement between OHC examiners and IMEs in the study population is striking, and includes all of the major areas of occupational medicine practice: diagnosis, work-relatedness, treatment recommendations, and disability assessment. Equally striking is the unidirectional nature of the disagreements. In only one case was there agreement between the IME and the OHC examiner on all of the issues. In every other case the IME argued for some combination of fewer or less serious diagnoses, fewer work-related diagnoses, less treatment, and a lower level of disability compared with the OHC examiner’s findings.

With regard to diagnosis, disagreement often centered on the number of diagnoses per patient. The OHC examiners made more diagnoses, with the effect of recognizing a broader spectrum of illness/injury than that recognized by the IMEs. For example, among patients with respiratory illnesses the OHC examiners recognized asthma and upper airway inflammation, whereas the IMEs would recognize only one or the other. For patients with musculoskeletal disorders the OHC examiners tended to include more parts of the body, such as cervico/thoracic strain along with shoulder impingement, compared with the IMEs’ diagnosis of shoulder impingement alone. Mental health issues such as depression were sometimes recognized by the OHC examiner and not by the IME.

Disagreements over work-relatedness had several common bases. If the IME did not recognize a diagnosis made by the OHC examiner, work-relatedness could not be attributed to a condition which, in the IME’s opinion, did not exist. In some cases IMEs emphasized the presence of co-existing disease, and in other cases the presence of pre-existing disease as an alternative explanation to work as an etiology. Another significant area of dispute involved cases of lingering symptoms/illness following cessation of workplace exposures. In some cases the IMEs did not recognize ongoing symptoms/illnesses reported by the patients and diagnosed by the OHC examiners. In other cases the ongoing symptoms were recognized by the IMEs, but were attributed to psychological causes unrelated to work.

Disagreements concerning treatment flowed to some degree from the disagreements over diagnosis and work-relatedness. IMEs did not recognize the need for treatment for conditions they did not diagnose. In addition, if the IME deemed the illness to be psychological in origin, the treatment generally recommended was return to work. In contrast, the OHC examiner argued for symptomatic treatment and exposure reduction. Overall, the OHC examiners were much more likely to recommend periods out of work and workplace restrictions and/or modifications than the IMEs were.

Disability assessment was the area where the discrepancies between the OHC examiners’ and the IMEs’ opinions were greatest. In 21 cases the IMEs assessed no disability. For those 21 cases the OHC examiners assessed a partial disability 12 times and a total disability nine times. Much of this difference was attributable to the different weights given symptoms, examination findings, and test results by the OHC examiners and the IMEs. IMEs were reluctant to recognize disability among patients without significant abnormal examination or test findings. Consequently, patients who had significant musculoskeletal pain reported to increase with various activities or upper and lower respiratory symptoms reported to occur with various exposures were deemed not, or minimally, disabled by the IMEs. In contrast, the OHC examiners recognized the patient history as a key component in assessing the severity of the illness and resulting disability. In a number of cases the IMEs did, however, recognize recurrent respiratory symptoms in association with specific environmental exposures, and recommended avoiding exposure (including not returning to the workplace where the patient had become ill). Despite this recognition, however, the IMEs assessed no disability.

Additional reasons for the discrepancies between IMEs and OHC examiners regarding disability assessment included:

1. cases in which the IME recognized a disability but deemed it non–work-related;
2. cases in which the IME diagnosed a psychological illness (i.e., “symptom magnification”) that he or she considered non-disabling;
3. the OHC examiner’s opinion that employers’ actions such as failure to accommodate or termination might contribute to the disability; and
4. the OHC examiner’s opinion that a need to avoid future exposure despite the lack of current symptoms constituted a disability as it impacted the individual’s ability to work.

**Differences in Skill vs Differences in Perspective**

One explanation for the identified differences between IMEs’ and OHC examiners’ opinions in this study is that the skill levels of examiners differ.\(^2,5,7\) Skill is here defined as a combination of training and experience that allows the examiner to gather appropriate information that is as comprehensive as possible to serve as a basis for clinical decision making.
All of the IMEs included in the study except one listed themselves as specialists and were presumed to be board certified in their specialties. In general it appeared the specialists chosen to be IMEs were trained in the specialties appropriate for the health problems they were asked to evaluate. For example, respiratory issues were usually evaluated by a pulmonologist, musculoskeletal problems by an orthopedist, and skin problems by a dermatologist. The exceptions were IMEs who examined several patients with problems hard to restrict to a single organ system. In those cases general internal medicine specialists were chosen. Many of the physicians performing as IMEs were known to the authors as practitioners with considerable clinical experience in their specialties.

It is not known how many of the IMEs may have had specialized training or experience in occupational medicine or disability evaluation. One IME described himself as a specialist in occupational pulmonary medicine, but specifically listed board certification in pulmonary medicine but not occupational medicine on his letterhead. He was also the only IME to list certification by the American Board of Independent Medical Examiners on his letterhead. Evaluations at the OHC were all performed by a physician board-certified in occupational medicine and a nurse practitioner with more than 12 years of experience at the OHC, who was certified in occupational health nursing and as a nurse practitioner by the American Nurses Credentialing Center.

It does not appear that differences in skill can explain the differences of opinion between the OHC examiners and the IMEs. Whether performed by IMEs or OHC examiners, examinations were conducted by experienced clinicians in appropriate specialties utilizing standard methods of eliciting histories and performing physical examinations. There were no major disagreements over the choices of diagnostic testing. In addition, the differences of opinion between the OHC examiners and the IMEs were remarkably similar across all specialties and individuals. In 22 of 27 examinations the patient was evaluated first at the OHC. Consequently, the IME was expected to respond to the issues raised by the OHC, providing an additional reason for the similarity of information obtained by the IME and the OHC examiner. If the differences of opinion were simply a matter of skill, more variation and less consistency among the differences would be expected.

The information gathered and utilized by the IMEs generally appeared to be similar to that gathered and utilized by the OHC examiners. In fact, for all but four of the examinations, the IME saw the patient after the OHC examiner and presumably reviewed the OHC examiner’s report and responded to issues raised by him or her. Consequently, the differences of opinion were based more on which facts were emphasized and excluded, and how the facts were interpreted and synthesized, rather than which facts were collected.

Contrasting IME and OHC Perspectives

It is likely that differences in underlying perspectives between the OHC examiners and the IMEs explain the differences of opinion. The ultimate effect of every IME examination except one would be to reduce the benefits injured workers might receive from workers’ compensation if only the OHC opinion were taken into account. This effect was produced through opinions that would reduce the number of conditions identified, the number of conditions identified as work-related, the treatment modalities (including workplace interventions) made available, and the extent of disability recognized. This unanimity of IME opinion likely reflects a common approach to the identification of work-related illness and disability.

The differences in IME and OHC perspectives include three fundamental issues:

1. How the reality to be studied is framed
2. How reality—the content within the frame—is to be described
3. Defining who may legitimately study and describe reality

Framing reality. To the IME, worker patients are inherently biased by their conscious and unconscious pursuit of secondary gains, rendering the history given by the worker patient untrustworthy. According to this perspective, worker patients are typically motivated by desire for financial gain, lack of motivation to work, disgruntlement over working conditions, or unfounded fear of workplace hazards, or are impaired by psychological problems. Consequently, observations or opinions the worker patient may have regarding the nature or magnitude of his or her symptoms, the exposure conditions potentially giving rise to his or her illness, or the impact of the illness on his or her capacity to work or engage in non-work activities is likely to be an exaggeration meant to maximize his or her financial or other benefits.\(^3,8,9\)

Since the IME considers the worker patient’s account untrustworthy, it follows that reality is defined as the collection of facts about a worker patient’s disease gathered through means independent of the worker patient’s observations, opinions, and effort. Parts of the physical examination, diagnostic testing, workplace air monitoring results, and standardized disability assessment protocols are examples of these means.\(^2,10\)

The OHC examiner, in contrast to the IME, not only utilizes information gained through worker patient observation, but considers such information essential to an understanding of the patient’s illness and the clinical decisionmaking process. \(^11\) The issues posed by a worker patient with an occupational illness or injury are often complex. Understanding how a workplace might have
contributed to such a patient's illness, or how the illness has limited the patient's capacity to work, is impossible to achieve without hearing from the patient. Despite striving for a comprehensive view of the worker patient's situation, considerable uncertainty is almost invariably present. From the OHC examiner's perspective, the patient's history and observations are necessary to limit that uncertainty to whatever extent is possible.12,13

Without denying that some worker patients may exaggerate the hazardous natures of their jobs or the impacts of their illnesses on their work capacity, the OHC examiner's experience is that the vast majority of worker patients would rather be employed then unemployed and on Workers' Compensation. Likewise, most workers would rather not strain relations with their employers by asserting their jobs have made them sick. Worker patients have an interest in working and in making sure their health is not put at risk by the conditions of their work. As a consequence of this interest and their knowledge of the workplace, they often have accurate opinions of what makes them sick at work and how overexposures and risk can be eliminated or diminished.14–18

Defining reality establishes a frame, determining what data are included within the boundaries, and what data are excluded. Establishing the frame requires a decision, and that decision reflects the values and perspective of the decision maker. The IME's frame is much more constricted than that of the OHC examiners, and the sizes of both frames flow from contrasting views of the value of information obtained from the patient.

Describing reality—method and bias. The IMEs and the OHC examiners agree that the method used to investigate an occupational ailment determines how the ailment will be seen. There is further agreement that the method should be empirical, with conclusions logically based on observations made of a given reality. And finally, IMEs and OHC examiners agree that method should be standardized, that is, applied uniformly to all patients. Using a standardized method, it is reasonable to expect different clinicians to reach similar conclusions in any given case.

Yet despite agreement on some of the fundamental issues related to method, IMEs and OHC examiners differed dramatically about how they respectively "saw" the 23 worker patients in this study. A major part of the differences can be attributed to the contrasting ways IMEs and OHC examiners frame the reality to be investigated, and set the bar of "proof," as described in the previous section.

The dispute between OHC examiners and IMEs with regard to method centers on the question of whether a particular method of investigation can ensure a view of reality that is unbiased, or complete and undistorted. IMEs claim their methods bestow a capacity to understand the reality of occupational disease clearly and without bias.3 From the IME perspective, the OHC's reliance on patient input is a fatal source of bias. In contrast, the OHC recognizes any method as inevitably impacted by social factors.10–21 Consequently, neither the IMEs nor the OHC can claim that their respective methods of investigation are free of bias. From this perspective an analysis of the type and extent of bias in each approach is necessary to allow a comparative evaluation.

As discussed above, IME methods severely limit both the type of information to be collected and the sources of that information. IMEs have defined "reality" to include only information obtained by methods that require little or no worker patient input. The IMEs further restrict their version of reality by requiring an unreasonable, often clinically inappropriate, and at times unobtainable level of proof to document a diagnosis, identify an etiology, determine appropriate treatment, or assign a level of disability. As a result, a closed loop is created in which only aspects of a complex reality are defined as the whole, and the methods that disclose that reality are naturally extolled as the only valid methods. The IME method is strongly biased toward minimizing the recognition of occupational illness and disability.10

From the OHC's perspective, IMEs have unnecessarily constrained their vision. The reality to be explored by the OHC examiner includes the physical examination findings and test results used by the IMEs, but also includes the worker patient's experience. While at times this inclusion may lead to erroneous observations for some of the reasons put forward by the IME, the overall effect from the OHC examiner's viewpoint is to add critical information to the picture. If the patient's experience is the reality to be studied, the patient's voice is necessary to "see" that reality as completely as possible.

The IME's perspective is also limited by the function and dynamics of the IME process. In the vast majority of cases in our study, the patient was evaluated first at the OHC and then by the IME. The IME's examination is typically done because the insurance carrier and/or employer questions aspects of the OHC opinion, and the IME is asked to address issues related to those questions. Consequently, the IME begins from a position of skepticism with questions that focus his or her attention in specific directions, rather than leaving the issues for investigation more open. In addition, the IME typically sees the patient once (and occasionally twice), often at a significant distance from both the onset of illness and the OHC evaluation. In contrast, multiple visits to the OHC offer an opportunity for a deeper understanding of the patient's ailment as it develops over time.

Who speaks? Defining who may study and describe reality. For the IMEs, knowledge about work-related illness is produced by experts whose educational backgrounds allow them to identify, assemble, and interpret the relevant facts. A clear distinction is made between the medical experts with the degrees and certifications and the lay people without. Distinctions are also made between experts. While physicians are all trained to diagnose and treat various diseases, special training in
occupational medicine is necessary to identify work-related etiology, and certification in disability assessment is a prerequisite to acknowledged expertise in this area.3,22 IMEs must rely upon others for knowledge about the workplace, exposures, and hazards that may play roles in a worker patient’s illness. Here, too, legitimate knowledge is produced by experts with the proper training and certification: certified industrial hygienists, safety engineers, toxicologists, and others.

From the IMEs’ perspective, worker patients are laypeople with little information to offer with regard to their medical conditions or their workplace exposures. The patient’s role in the medical evaluation and treatment process is essentially to submit to the examination and testing, and to comply with the treatment regimen ordered by the physician.

In contrast, the OHC examiner sees knowledge about the worker patient’s condition as arising through an active collaboration between the physician and the patient. Both clinician and patient bring expertise to the interaction. In the OHC’s experience, worker patients are routinely quite knowledgeable about their workplaces. Their knowledge often plays a crucial role in helping both themselves and the clinician understand what factors at work might be causing or contributing to their ailments. In addition, a worker patient’s knowledge of his or her workplace is often crucial to developing realistic strategies for accommodations and workplace changes necessary to keep him or her working safely. Beyond the workplace, worker patients “know” themselves and their bodies. This knowledge is key to understanding what treatments are likely to be effective, and how the illness or injury has impacted the patient’s ability to work and function in daily life. Finally, the knowledge conveyed by the patient through the history he or she gives the clinician is essential to the diagnostic process itself.11,23

IMEs also consider the worker patient’s treating physician to be prone to the same biases as the patient. In the IME’s eyes, the treating physician is enmeshed in a traditional doctor–patient relationship. In that role the physician functions as a patient advocate rather than objective observer. Seeking to preserve that relationship, the physician often pleases the worker patient by giving opinions the patient wants to hear, rather than what is medically or scientifically justified.

From the OHC’s perspective, the patient’s treating physician often contributes useful information to the clinical process. One of the strengths of the traditional doctor–patient relationship is the development of the relationship over time through repeated interactions. As a consequence, the physician can develop a relatively deep and overall understanding of the patient, putting him or her in good position to judge the role of primary and secondary gain issues when the possibility of work-related illness is raised. For example, the treating physician who corroborates that a patient’s asthma has been quiescent for years before a recent exacerbation contributes important information to the assessment of work-relatedness.

The OHC’s experience is that treating physicians are much more variable in their approaches to patients than described by IMEs. Physicians face a variety of pressures, incentives, and cultural currents that shape their attitudes and practices in ways similar to those advocated by the IMEs. The changing nature of medical practice has increased pressure on physicians to see more patients in shorter time periods, pushing physicians to concentrate on issues deemed medically serious and/or easily treated or dealt with.24 Many work-related health issues do not fit into either of these categories (at least from the treating physician’s point of view) and consequently are often turned away with an “I don’t really know much about that,” silence, or referral. Physicians often see workers’ compensation claims as an additional burden on their time and many are choosing not to participate.25 Physicians are being utilized in gatekeeper roles in other benefit systems, however, and as such are expected to take on the role of protector of various private and public purses. This role dovetails with the dominant cultural currents of the day. The idea of personal responsibility for one’s actions and life situation is one such theme in contemporary American life. This is reflected in the medical encounter by an emphasis on personal choice, lifestyle, and psychology as causes of health problems. As a consequence of these roles and pressures, many physicians assume a generally skeptical approach to patients. Consequently, statements by patients are not necessarily accepted at face value, but are critically assessed for the same sorts of lurking secondary gains noted by the IMEs. In effect, this leads many treating physicians to conclusions regarding work-related conditions that are similar to those put forward by IMEs.21

In addition, it seems that fewer patients, often due to insurance issues, stay with one treating physician long enough to establish the kind of bonds that would encourage the physician to either be knowledgeable enough or feel strongly enough about the patient to advocate for him or her (either in the way described by the IMEs or in other more positive ways).* Faced with many incentives to ignore, deny, or de-emphasize occupational ailments, when a treating physician does advocate for a worker patient made ill at work, it is likely to be due to a strong and well grounded opinion rather than a desire to please the patient.

Putting Perspectives in Context

The differences in perspectives between IMEs and the OHC have significant concrete effects on worker

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*Personal communications from a variety of local union officials.
patients seeking workers’ compensation benefits and on the insurance carriers and employers who pay those benefits. It is difficult, based upon the results of this study, to escape the observation that the immediate effects of an IME are typically to reduce benefits for worker patients and to reduce costs for insurers and employers. When it is recognized that virtually all IMEs are paid for their work by employers and insurers, rendering them financially dependent on those payers, the IMEs’ claim to know “the” reality of occupational illness becomes even less tenable. Employers are quite clear about their view of the role of IMEs, seeing them as an important counterweight in a system they perceive as overly generous to injured workers. “Years ago people could take advantage of comp by talking their own doctor into anything,” wrote a corporate executive in a letter to company employees, and “It’s not so anymore…” thanks to the IME.†

In the broader medical context the biomedical model, upon which the IMEs’ perspective is based, has been subjected to scrutiny and criticism for many years and from a variety of perspectives.12,21,26–28 These critical perspectives, whatever their differences, share a core tenet: that the patient’s experience is essential to an understanding of his or her illness, of how the illness might be most effectively treated, and of how the illness impacts the patient’s life. Analogously, in occupational medicine the worker patient’s knowledge, observations, and experience are central to an understanding of all aspects of his or her illness. Only through inclusion of the worker patient in the process of diagnosis, determining work-relatedness, developing a treatment strategy, defining preventive measures, and assessing disability can a better understanding of “reality” be obtained and a higher likelihood that safe work, effective treatment, and appropriate benefits for the worker patient be attained.

References

†Letter to employees from an executive at a large printing and binding operation, September 2001.


24. Gabriel BA. The doctor will see you now: are physician office visits getting shorter or longer? AAMC Newsroom Reporter, April 2001.