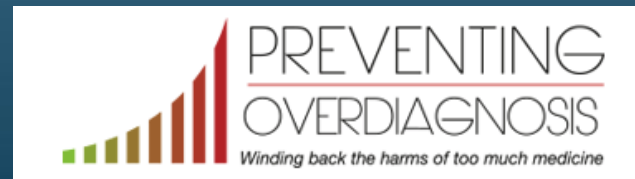


Overdiagnosis of Psychiatric Disability:
Best practice, Advocacy,
« Complaisance »,
Fraud or Ignorance?

Dr. Fabien Gagnon, MD, D.Psy., FRCPC

Forensic psychiatrist
Professor, Université Laval
Institut Médico-Légal de Québec



Quebec City, Quebec, Canada
August 18, 2017

Thanks to the
Organizing Committee.

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Disclosure

- No relationship with the private industry.
- Work as a forensic psychiatrist (*do occupational psychiatry work*) doing IMEs and FFD evaluations for employers, unions, WCB, insurance companies, lawyers, tribunals...

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We will talk about...



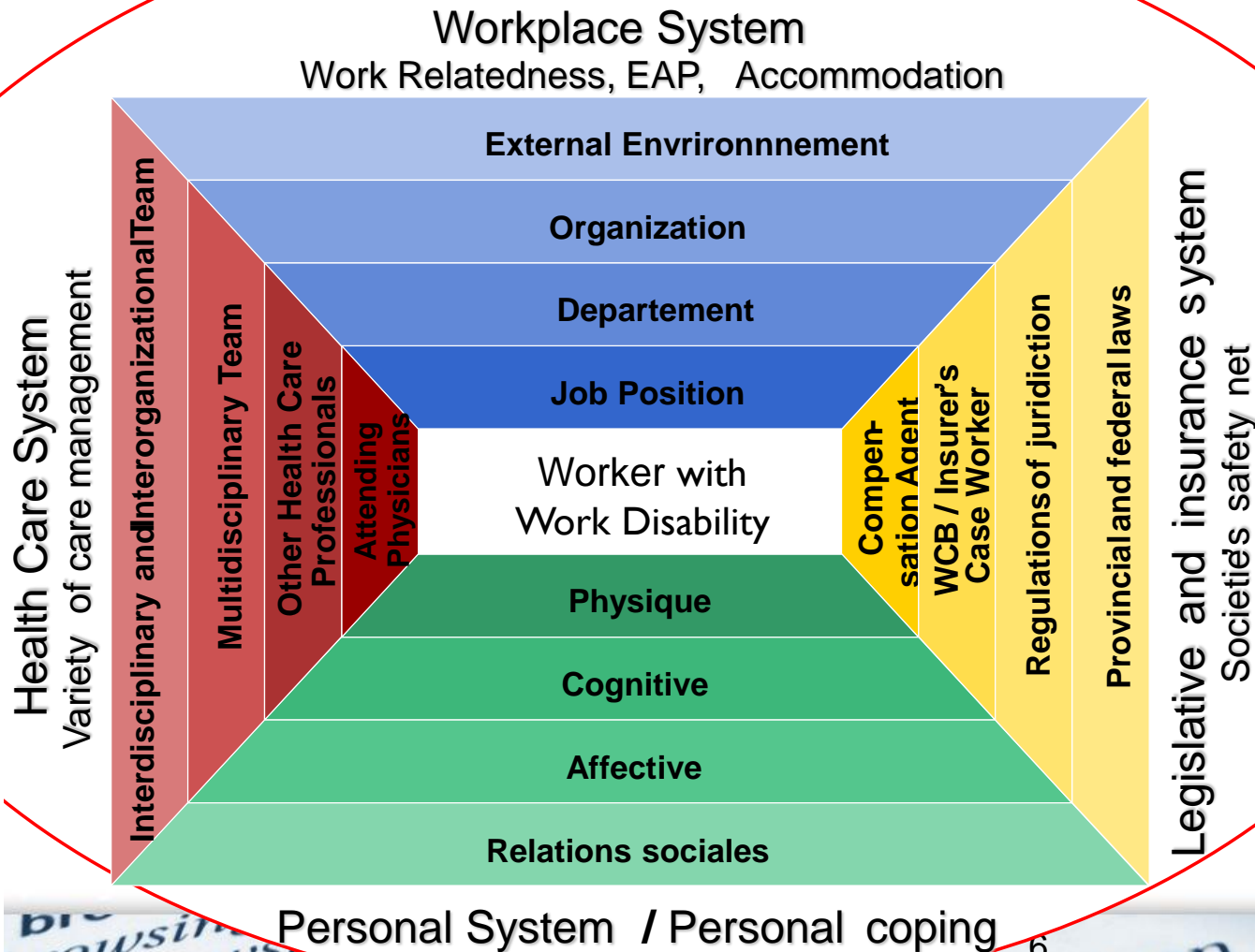
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« Objectives »

- Look at « probable » explanations (*and approach*) for the clinically observed trend in overdiagnosing (or misdiagnosing) psychiatric disability.
 - Do best practice guidelines, psychiatric classifications, or physician's advocacy role influence that phenomenon?
 - Should physicians with a « sympathy bias » for their patients be sued for fraud?
 - Should ignorance be invoked?
- Underline the importance of educating medical students and treating physicians on disability issues.

Work Disability is Complex

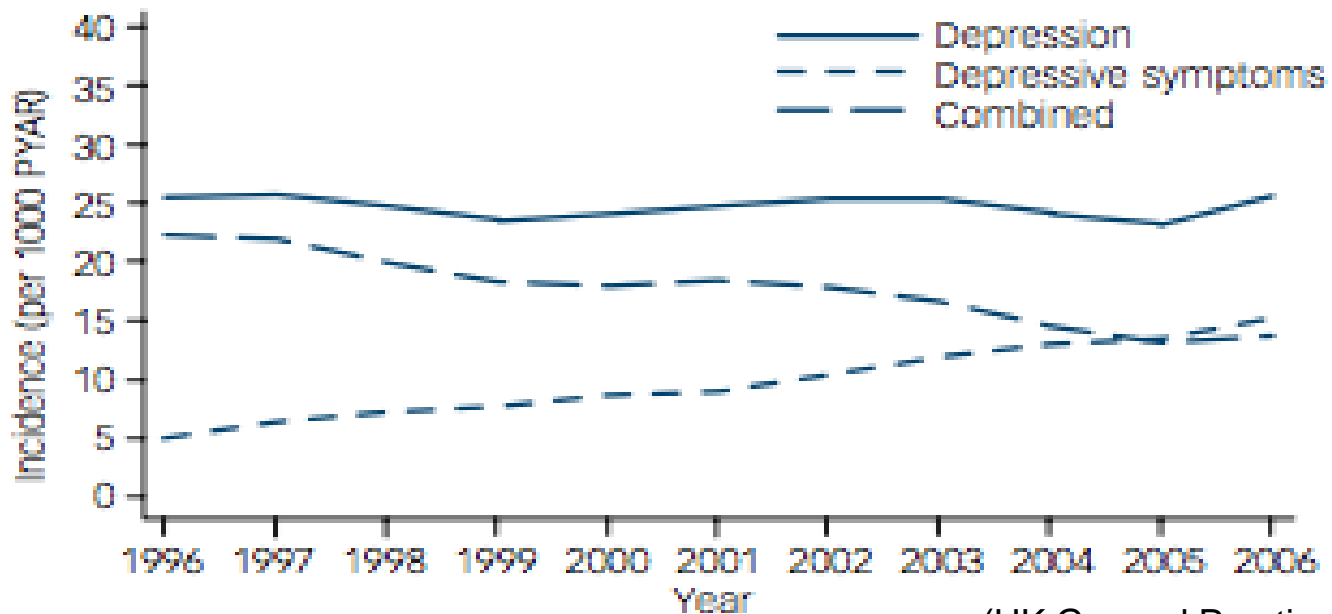
Global Context In Society



Loisel et al,
J Occup
Rehabil,
2005, 15 (4),
p. 507-24.

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Increasing prevalence of depression...



(UK General Practices)

Fig. 1 Incidence of diagnosed depression and depressive symptoms.

PYAR, person-years at risk.

(Rait et al, 2009)

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Prevalence of MH Disorders varies... near to ¼ of the population in U.S.A. vs

Table 1
Prevalence of disability by type, aged 15 years and older, Canada, 2012

N.B.: Depression
Anxiety

Disability type	Population	Percentage
Total disability	3,775,900	13.7
Pain-related	2,664,200	9.7
Flexibility	2,078,000	7.6
Mobility	1,971,800	7.2
Mental health-related	1,059,600	3.9
Dexterity	953,100	3.5
Hearing	874,600	3.2
Seeing	756,300	2.8
Memory	628,200	2.3
Learning	622,300	2.3
Developmental	160,500	0.6
Unknown	79,500	0.3

Note: Individuals may have more than one type of disability; therefore, the sum of all individual disability types is greater than the number of "total disabilities".

Source: Statistics Canada, Canadian Survey on Disability, 2012.

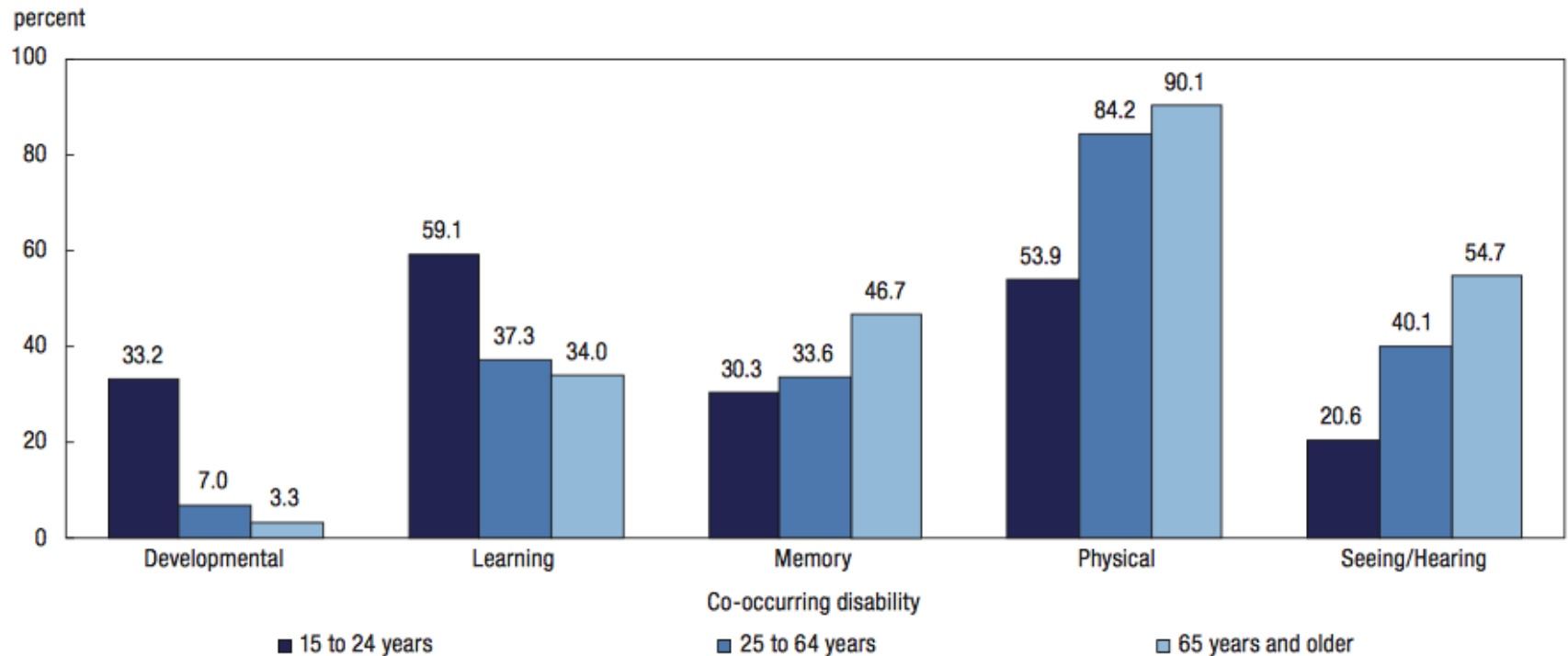
(Statistics Canada, 2012)

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With aging, increasing co-morbidity... MH disorders + physical...

Chart 2

Prevalence of co-occurring disability types among adults with a mental health-related disability, by age group, aged 15 years and older, Canada, 2012



Note: Physical disability includes mobility, flexibility, dexterity, and pain-related disability types.

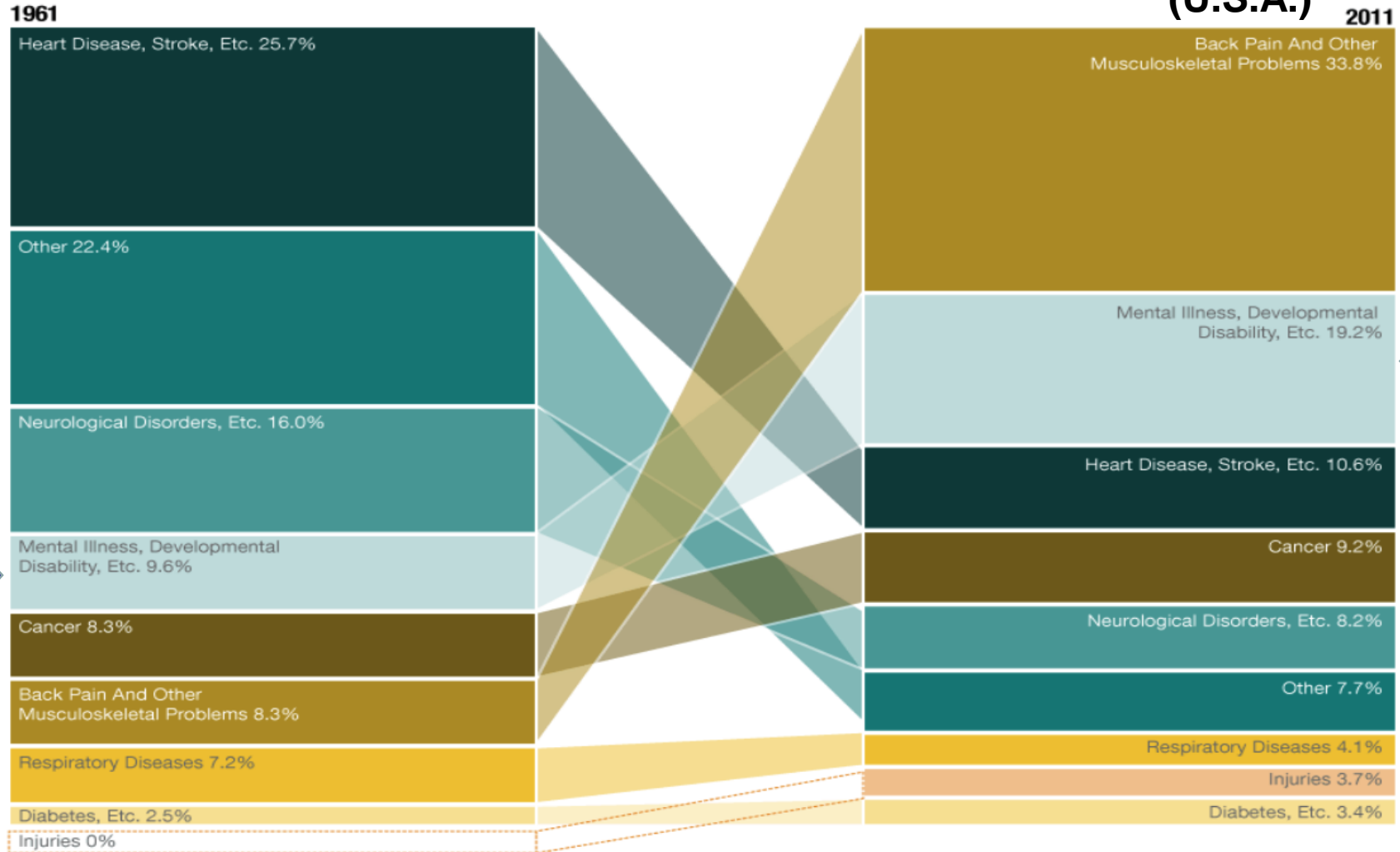
Source: Statistics Canada, Canadian Survey on Disability, 2012.

(Statistics Canada, 2012)

Increasing disability due to MH disorders

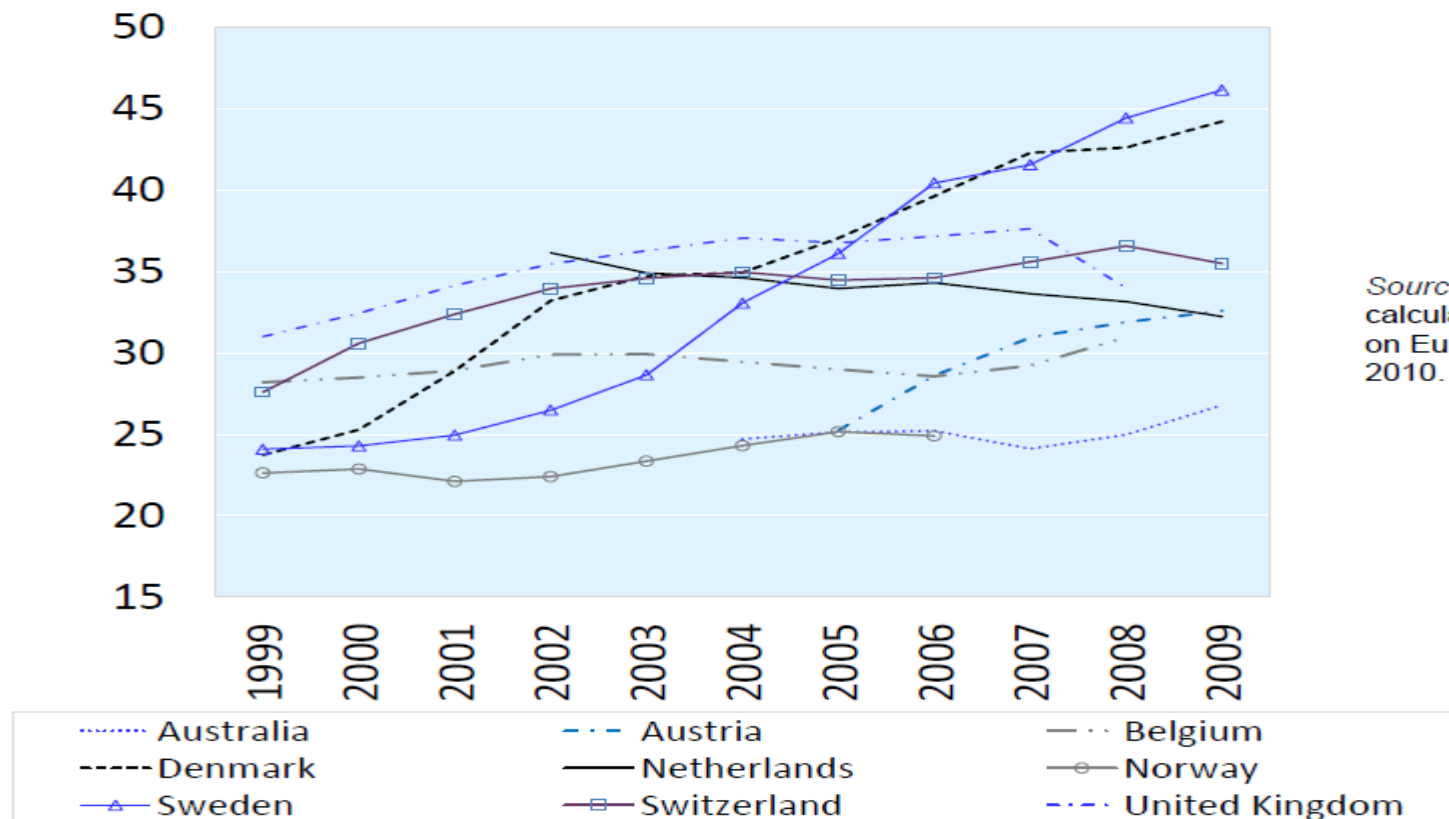
Share Of Newly Disabled Workers, By Diagnosis

(U.S.A.) 2011



Increasing disability due to MH disorders

New disability benefit claims due to mental disorders (in % of total claims)

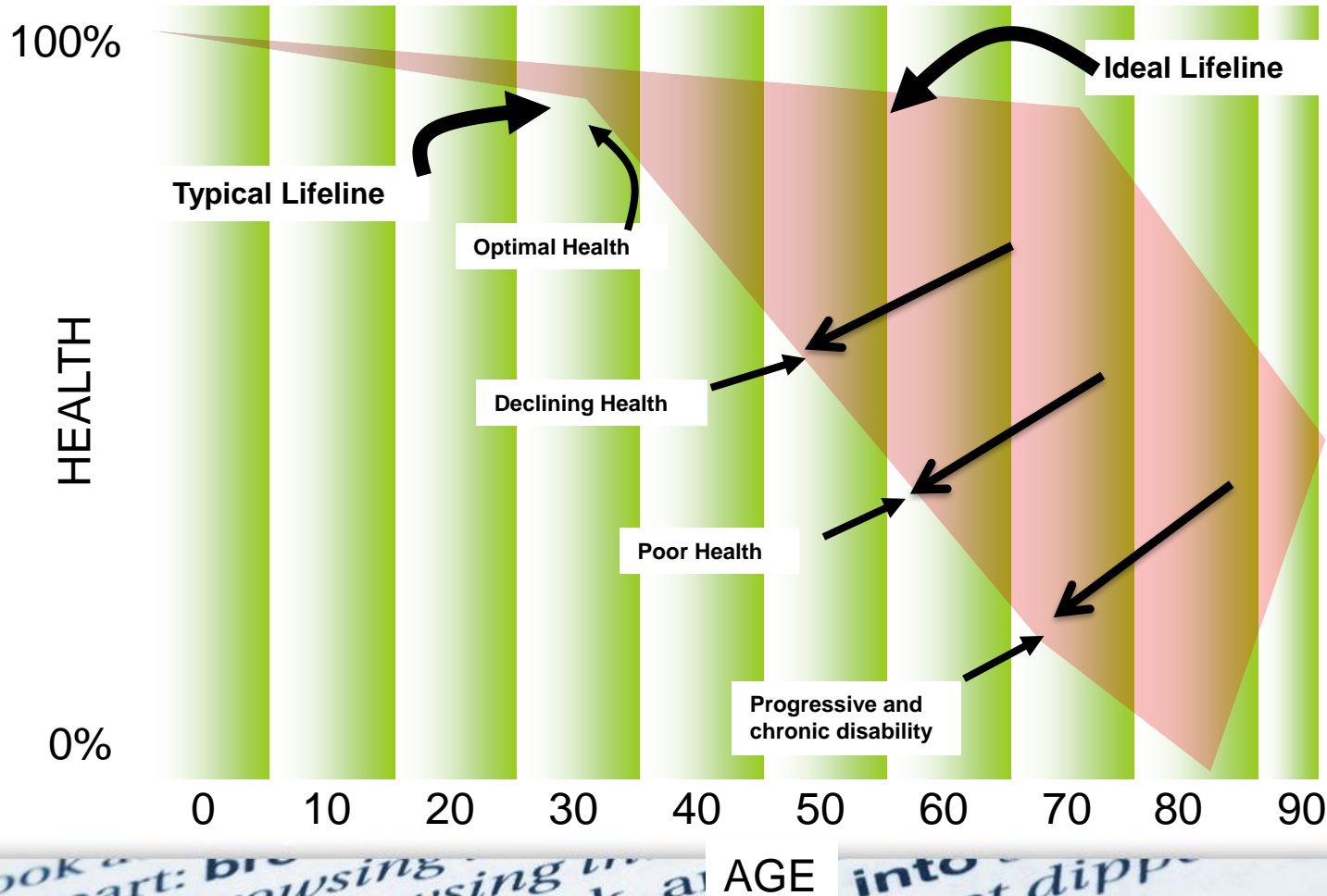


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Get prepared! Aging, Health and Work...

Toward Progressive and Chronic Disability...

Impact of Lifestyle on Health and Work



Adapted from:
What is healthy
aging in The 21st
century?
Westendorp RGJ
Am J Clin Nut,
Vol. 83, No. 2,
404S-409 (2006)

IME Observation

«Independent medical examiners often meet examinees who are put on sick leave by their treating physician, even though there is no medical evidence. »

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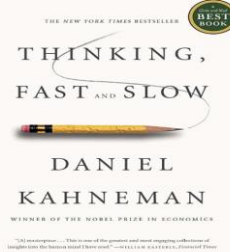
Some IME Observations

- Pt says he/she feels not ready to RTW (different reasons e.g. problem with superiors or colleagues)... How does the GP (medically) evaluate disability?
- RTW postponed by nurse practitioner or family medicine resident... vs GP document recommending RTW...
- The GP maintains disability till he/she comes back from vacation...
- GP says that he/she indicates « major depression » on the sick note to make sure the pt will receive insurance benefits.
- GP « feels » the pt's work environment is toxic, but gives 80% at GAF (DSM-IV-TR)...

• Etc.

Already some problems with the
« Diagnosis of Psychological Disorders »

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THE INTELLIGENT CLINICIAN'S GUIDE TO THE DSM-5®

Joel Paris



"Dr Paris has written a wise and well informed book that will help readers understand and avoid the problems created by DSM-5."

— Allen J. Frances, MD

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OXFORD

- Often clinicians do not read the definition of Mental Disorder.
- Clinicians mostly use Heuristics, rely on « impressions », not criteria.
- Normal reactions becoming « psychiatric »...?
- DSM not a Bible...
- Trend toward **Overdiagnosis in Psychiatry**
(Paris, J., 2013, 2015)

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Increasing prevalence of depression... GPs use \pm criteria...

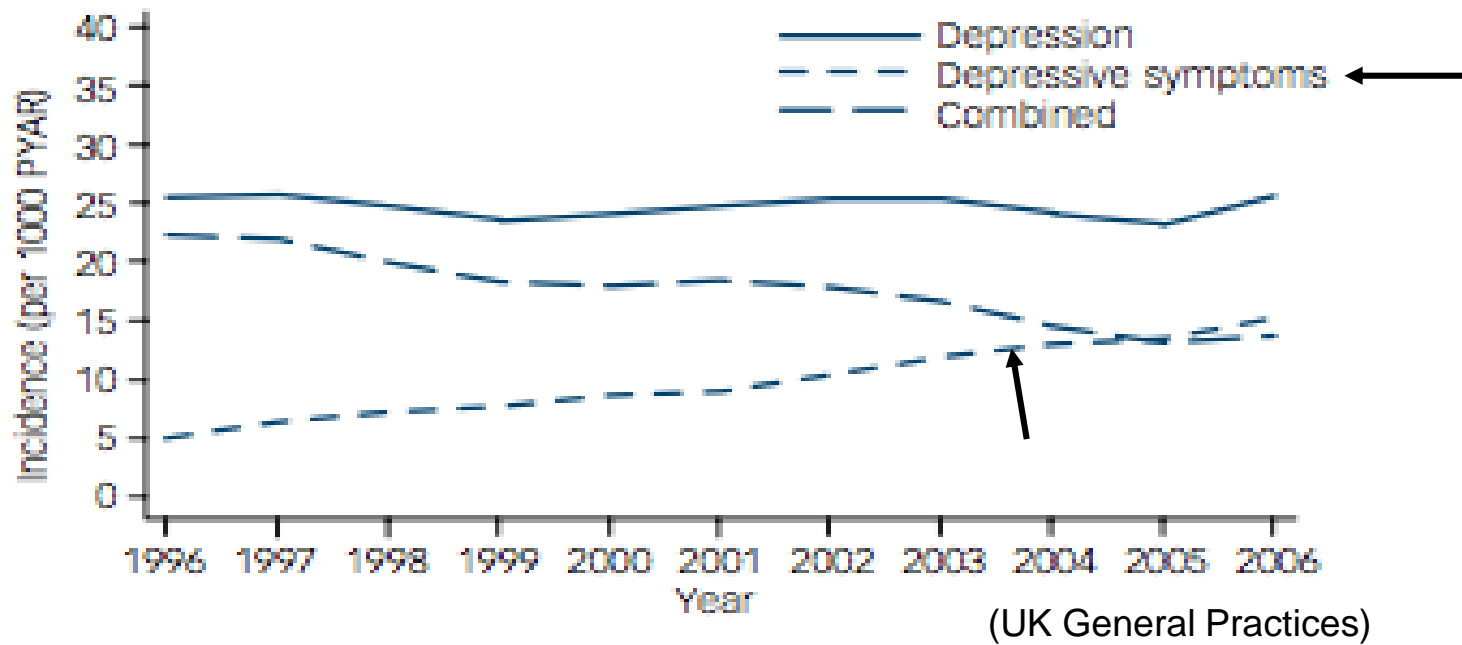
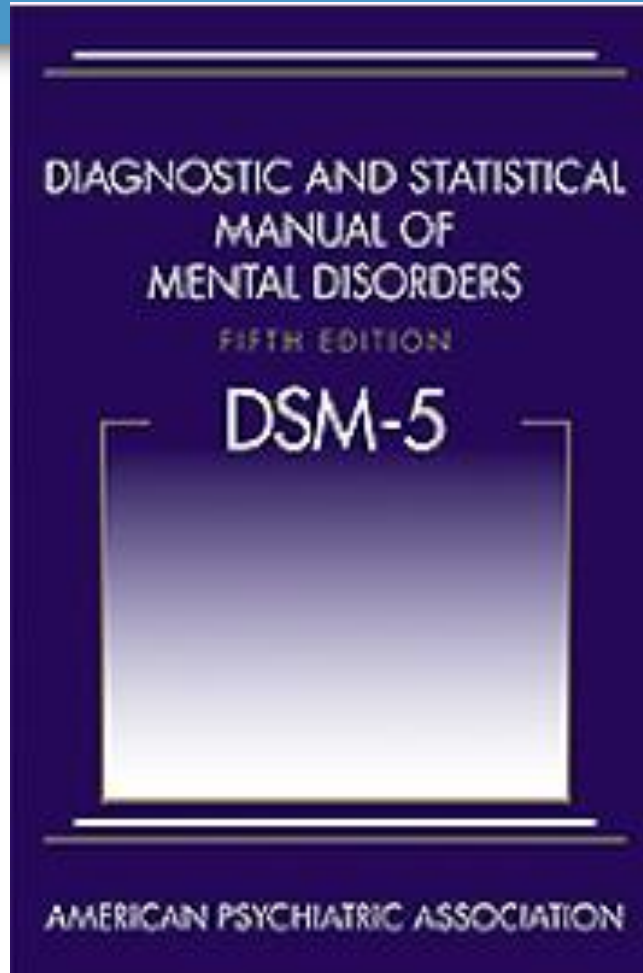


Fig. 1 Incidence of diagnosed depression and depressive symptoms.

PYAR, person-years at risk.

(Rait et al, 2009)

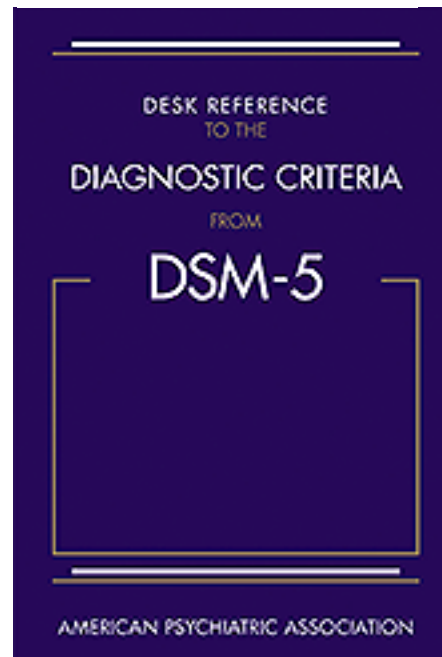
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DSM-5 / ***Global spectrum**

**ICF and WHODAS-2.0
Vs
GAF**

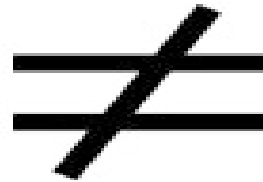
* Risk of overinclusion



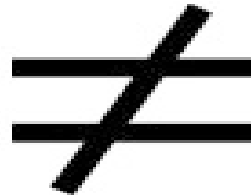
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MH professionals often forget (or do not know how)
to distinguish...

« **Diagnosis** »



Handicap / Functional Limitations



« **Disability** »

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What about the
« ***Diagnosis of Psychiatric Disability*** »?

Disability Assessment?

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Sources of variation causing low inter-rater reliability in medical evaluations

(modified from Kobak et al, 2009; in Barth et al, 2016)

Interaction between expert and claimant

- **Information variance**
 - Experts obtain different information as a result of asking different questions
- **Observation variance**
 - Experts differ in what they notice and remember when presented with the same information
- **Interpretation variance**
 - Experts differ in the importance they attach to what is observed
- **Criterion variance**
 - Experts use different criteria to score the same information

- **Within subject and within expert**
- **Claimant variance**
 - True differences exist in the claimant when claimants say different things to each expert or when claimants truly change between a first and a second interview
- **Expert variance**
 - Experts differ in their understanding of the demands of a certain job on the workers' capacities and of the consequences of functional limitations on work performance
 - Experts differ in their personal value system on what level of effort, endurance, and discomfort can reasonably be expected by a claimant
 - Experts differ in their understanding of the legal requirements on a medical expertise that could affect their medical judgments

Sympathy Bias and/or Pt. Advocacy

Strong influence of MD-Pt relationship...?

VS

Good Medicine

Objective and Comprehensive
Assessment and Management

VS

Ethical approach...

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Over / Mis-dx of MH Disability

« Complaisance » ?

Is "Gaming the System" really OK?

Fraud ?

Ignorance ?

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How should we deal with it?

Can we change it?

- Complaisance : Deontological Complaints...

C-F-I

Process time consuming...
Considered for years...but...
Probable low impact...

- Fraud: Criminal charges...

- Ignorance : No professional should ignore the law...

MD « declared » the pt's work disability

≡ Mis-diagnosis...or Overdiagnosis?

Do they know the impacts?

***Do clinicians really give an
“Informed Medical Opinion”?***

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Not a new problem...

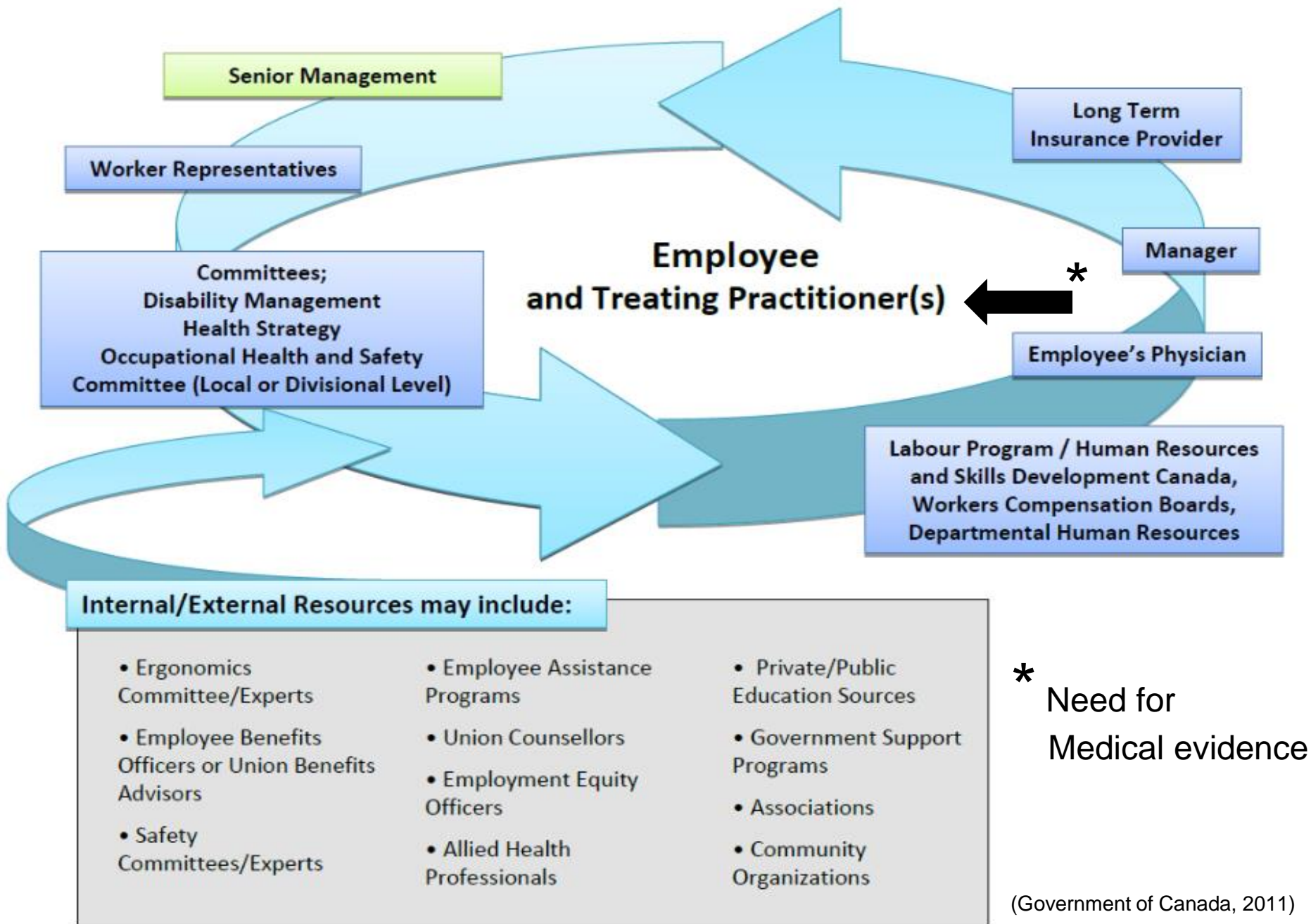
“Gap in Mental Health Disability Evaluations”

As the numbers of disability and other work capacity evaluations has increased over the years, the gap in mental health disability training has become increasingly problematic. ***The lack of postgraduate and continuing education training opportunities has resulted in a distressing variability in the quality of disability and other occupational capacity evaluations.*** Clinicians utilize idiosyncratic methods, which lack grounding in the available data regarding mental health and work dysfunction, and which increase the risk of the influence of bias, particularly advocacy bias, influencing opinions.

(Gold et al., 2009)

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Figure 7: Principle Stakeholders in a Workplace-Based Disability Management Program



MD's Duty...

- To the patient
- To the profession
- To the society... since someone will pay for it...

(van Dijk, et al., 2016)

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Duty to the society...

Le triangle de l'éthique

Quand un « Ça ne va pas ! » émerge à l'intérieur de nous, il est utile de questionner la dimension éthique du problème en cherchant à équilibrer 3 pôles :

TU représente le patient dans la situation familiale qui est la sienne, avec son histoire, ses expériences, ses connaissances, son vécu, ses valeurs...

JE représente chacun des soignants impliqués dans une décision et dans sa mise en oeuvre, avec ses expériences, ses connaissances, ses émotions, ses valeurs, ses questions...

TU

?

ILS

ILS représente l'ensemble de la société, faite d'individus, d'institutions, de cultures, de traditions, de normes, de champs disciplinaires...

Quelques questions peuvent soutenir notre démarche :

Quel est le sens de ma décision et/ou de mon action pour le patient ?
pour moi-même ?
pour la société ?

Comment pourrais-je définir ce qui ne va pas dans cette situation précise ?

Quelles sont les valeurs qui ne sont pas respectées ?

Quelles sont les limites des différentes personnes en présence ?

La dimension éthique d'une décision implique la recherche d'un équilibre entre ces 3 polarités et la construction d'un NOUS qui permet à chacun d'être partenaire de la décision

Lorsque prédomine le

TU



Au détriment du ILS
La décision prise vise la satisfaction immédiate du patient, sans tenir compte des recommandations de bonne pratique, des lois, des règles qui permettent d'argumenter un choix.

Risque
Biais de complaisance.



Au détriment du JE
Pour répondre aux besoins et/ou aux attentes du patient, le soignant oublie ses propres limites ; il se surinvestit dans la situation.

Risque
Épuisement professionnel, burn out.

Lorsque prédomine le

ILS



Au détriment du TU
La singularité du patient n'est pas prise en compte ; il est réduit à l'application d'une règle. La décision se prend sans tenir compte d'éléments contextuels.

Risque
Dépersonnalisation du soin ; absence d'investissement du patient dans son traitement.



Au détriment du JE
La décision prise est soumise aux règles de la société, aux normes institutionnelles, aux recommandations de la science, mais elle ne fait pas sens pour le soignant.

Risque
Absence d'investissement du soignant, fuite, agressivité, cynisme.

Lorsque prédomine le

JE



Au détriment du TU
Le soignant fait primer ses propres convictions, son propre désir ; il accorde peu d'importance aux attentes réelles du patient.

Risque
Apparition de plaintes à travers lesquelles le patient cherche à s'exprimer. Absence de relation de confiance.



Au détriment du ILS
Le soignant fait de son propre désir le moteur de sa décision, mais il ne tient pas compte de la société dont il fait partie.

Risque
Erreur médicale, transgression des normes, des lois. Impossibilité d'argumenter ses choix en fonction des valeurs et règles qui les sous-tendent.

En favorisant un équilibre entre ces 3 polarités, nous cherchons à développer un discernement éthique. Si c'est le cas, nous sommes capables de rendre compte des choix qui sont faits et d'expliquer en quoi ils permettent d'agir dans le souci de bien faire.

© 2017, Boite à outils de l'éthique, Weaylich.

D'après S. Bouliane et P. Firket (2013) : Teaching Moment: Aborder l'éthique en supervision clinique : une approche en trois temps, Canadian Family Physician

http://www.provincedeliege.be/sites/default/files/media/7780/5_triangleethique_laurent.pdf

Don't we have a duty... to...?

***Invest into
the education of
medical students
and physicians
on disability issues***

(CMA, 2010, 2013; de Boer et al., 2008, de Wind et al., 2016; Gold et al., 2009, Government of Canada, 2011; Maness et al, 2015; Minihan et al, 2004; Physician Education Project, 2000; Pransky et al, 2002; Régis, C., 2004); Russell et al, 2005; Soklaridis et al, 2011; Taiwo, O.A. et al., 2008; van Rijssen et al, 2015)

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Conclusion

Need for research on Models for Training

(including developing standards for disability assessment, disability management, return to work)

Medical Students and Physicians on Work Disability Assessment and Management, and their Efficacy.

(van Rijssen et al, 2011, 2015)

We did not talk about...

- Occupational problems...
- The impact sociological (cultural) influences...
- Shared-Decision Making and Work Disability.
- The availability of MH services.
- The influence of work environment on symptoms and their evolution.
- The influence of litigation on symptoms and their evolution.
- And many more issues...

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Important to differentiate

Diagnosis of Psych Disorder
VS
Diagnosis of Psych Disability

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Thanks!

fgagnon.psy@fmed.ulaval.ca

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Appendix A
Some suggestions for a
Medical Disability Assessment Training Agenda

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Some suggestions for a Medical Disability Assessment Training Agenda

- Don't forget the importance of the physician's assessment on the Medical Evidence Clause;
- Work Disability is a diagnosis, which goes beyond the simple diagnosis of the patient's medical condition;
- Diagnostic of Work Disability supposes that the physician as personally assessed (or as closely supervised the medical assessment) the patient (medical condition, psycho-social situation, functional limitations, Activities of Daily Living, hobbies, etc.);
- The diagnosis of Work Disability takes into account the other professionals assessments but is not dictated by other professionals;
- Before declaring Total Work Disability the physician must get a better idea of the patient's work (type and conditions), and criteria for disability;
- Read the physician forms which indicate the Terms or Conditions of Insurance Clause of Total Work Disability;

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Some suggestions for a Medical Disability Assessment Training Agenda

- Partial Work Disability is not Total Work Disability;
- Fitness to work may differ from Total Work Disability;
- Are there accommodations which would facilitate the patient's RTW? – For how long?;
- Causation analysis requires the physician to consider aspects which go over the simple medical diagnosis (e.g. PTSD vs WCB conditions);
- A diagnosis of Work Disability must be accompanied by a Treatment Plan **and** RTW plan (defined treatment objectives allowing RTW as quickly as possible);
- RTW is also a strategy to optimize the patient's social participation and well-being;

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Some suggestions for a Medical Disability Assessment Training Agenda

- Are there restrictions (permanent or temporary), or limitations (temporary or temporary) ? On which medical basis?;
- Beware of functional limitations based essentially on subjective elements (from the patient's, other professionals', or MD's part);
- What is the impact of stress-related to RTW has on the patient's condition; Is there still a medical condition or is it now an occupational problem;
- Is the patient consciously, or not, exaggerating his/her symptoms?;
- Occupational problems don't resolve by medication and/or sick leave;
- A Work Disability Diagnosis requires the physician to reassess if the patient's evolving condition still indicates to maintain on SLS/LTD, or readiness to RTW.

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Appendix B

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