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## THE NATURE OF THE PEER REVIEW PRIVILEGE UNDER THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986 (HCQIA)—TWO CASES

**Elliott B. Oppenheim**

### *Introduction*

The legal system's seeming inertia serves to ensure that issues are fully aired. Because matters of privacy are on everyone's mind since the Internet has opened up so many possibilities for making any and all information widely accessible, legislators and courts have been straining to frame rules that can keep private information safe. Yet, when a party shows a need to know, when there is no other source of information, and when information contained in a document affects health care, the likelihood increases that a court will open documents and weigh the competitive interests. Two recent cases test this view in the context of the peer review privilege and its nexuses with the Health Care Quality Improvement Act of 1986.

### *Credentials Committees*

Entry into medical practice by joining the staff of a hospital is accomplished when the hospital's credentials committee<sup>1</sup> "credentials" the practitioner. When adverse action is taken against a licensed independent

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## CLINICAL PROBLEMS WITH USE OF THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE<sup>1</sup>

**Alan D. Lieberman**

Most commentators, be they legal or medical, advocate use of the Durable Power of Attorney for Health Care (DPAHC) as the advance medical directive (AMD) of choice. Clinical physicians, however, tend to find that DPAHCs create more problems than benefits. Having practiced internal medicine for more than twenty years and having served on a hospital bioethics committee for an additional ten, this author shares the clinicians' opinion that a "naked" DPAHC; i.e., one without an accompanying instructional directive, usually turns out to be an unreliable, inappropriate method of maintaining patient autonomy. A recent case brought to the attention of the Norwalk Hospital Bioethics Committee gives evidence of an additional concern to be added to the sizeable list of problems previously identified. It results in part from the specific wording of the Connecticut DPAHC statute, but would apply in most other jurisdictions as well.

A.C., a well-educated, highly intelligent and previously healthy woman of ninety years was admitted to the hospital in a comatose state after suffering an acute stroke. Two months prior to her admission

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## WHERE DOES IT HURT? ANOTHER LOOK AT RE- SPONSE CONSISTENCY

**John M. Smothers and Peter  
G. Bernad**

### *Introduction*

During medicolegal evaluations, clinicians find that patients sometimes do things that just do not sit right. Physicians sometimes see this as well when conducting Independent Medical Evaluations (IME) to determine if claimants can return to work. Finally, claimants say many things about themselves, sometimes through comprehensive self-report inventories like the MMPI.

In this article, we will begin by considering a few clinical vignettes where patients' behavior teaches us about their believability. Clinicians use functional capacity evaluations (FCE) to assess patients' physical resources for return to work. We describe patient conduct during these evaluations that may tell us about a patient's ability and motivation to return to work. Clinicians use self-report inventories to describe their patients' states. Through their responses, people tell us about themselves and their troubles. We want to learn whether patients show believable consistency in their reports.

### *Malingering Definitions Revisited*

In an earlier article,<sup>1</sup> we presented DSM-IV's<sup>2</sup> definition of malingering. This definition describes people who malingering as consciously and deliberately falsifying their situation for external gain. People who consciously or unconsciously distort the truth

about their medical situation for reasons other than personal gain, such as to maintain their relationship with health service professionals, are not malingering. We stand by this definition. In this article, we will describe other reasons why patients may not bring their full effort and complete candor to clinical evaluations.

Berry and Butcher<sup>3</sup> cite Rogers,<sup>4</sup> discussing his adaptional model of symptom falsification. According to Rogers:

The claimant can view forensically toned evaluations as adversarial. The claimant believes that she or he has something to gain or lose from what he or she says or does in response to evaluation questions and problems. The claimant believes that she or he has no other way to make their point than to manipulate evaluation results.

So the claimant can feel at odds with the evaluator and can feel angry and anxious while trying to make his or her point by dissembling about his or her thoughts, feelings, and behaviors. In this setting the claimant may believe she or he is making the best of a situation thought to be unfair and bad.

Berry and Butcher also cite Putnam and Millis<sup>5</sup> who report that patients organize their bad physical feelings around their accident, seeing the accident as the cause or aggravator of patient troubles.

### *Clinical Vignettes*

One of us (PGB) reports vignettes from Independent Medical Evaluations. He remembers a patient who presented himself as painfully on crutches for a disabil-

ity evaluation associated with his marked limitations in mobility. The clinician evaluated him. After the evaluation, the clinician stood by his office window. He saw his patient striding across the parking lot below. The claimant tossed his crutches in the bed of his pickup truck and smartly drove off.

In another instance, attorneys asked Dr. Bernad<sup>6</sup> to conduct an IME of a claimant who complained of profound balance problems. Dr. Bernad had to travel out of state to do the evaluation. The attorneys scheduled evaluation space at a community medical school. Having arrived early, Dr. Bernad looked out of the window to see a woman walking briskly and purposefully toward the building. Shortly after that he heard the elevator moving and the woman stepped out. Upon seeing Dr. Bernad she leaned against the wall and slowly made her way to the evaluation room. When Dr. Bernad asked the claimant about her brisk walking pace outside the building, she crisply informed him that she wished to consult her attorney.

In another interview with a professional who reported neck injuries and incapacitating head injuries, Dr. Bernad observed that if he committed the claimant's complaints to writing, the claimant might lose his license. The person paused, and then asked Dr. Bernad to delete head injury complaints.

While doing IME physicals, Dr. Bernad encounters claimants who report limited range of motion and show the same. The clinician sometimes talks with the patient about recreational matters while repeating a part of the evaluation

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*(Consistency, cont'd from Page 3)*

where he encountered limited physical movement. Doing so, while the conversation distracts the claimant, he may find that the claimant's flexibility improves significantly. Reynolds<sup>7</sup> characterizes our first three vignettes as "blue elephants." Once we see one, we know that all elephants are not gray. Similarly when we see someone do something at marked variance with their presenting complaint, we find their complaint no longer credible.

Still, we have our third example. Does the person do more poorly at first because he or she is deliberately withholding information, or do other processes create and contribute to the person's response variability?

*Functional Capacity Evaluation (FCE)*

Lechner et al.<sup>8</sup> write that muscular and joint disability is "a leading cause of limitations in the ability to perform work. Musculoskeletal disability costs the United States an estimated 1% of its gross national product annually, predominantly in direct costs due to lost wages." The writers also report that insurance carriers, attorneys, the Social Security Administration and Workers Compensation Offices want quantitative measures of functional work capacity. According to Lechner et al.,<sup>9</sup> "traditional physical evaluation procedures," like muscle strength assessment, joint range of motion, interpreted radiographic findings, and recorded medical symptoms, may not clearly predict the person's physical abilities to work. So, Lechner<sup>10</sup> works to develop standardized functional capacity evaluations.

By this she means that she wants to create evaluation tasks and evaluation instructions that stay the same from one client to the next. Also, she wants clear and reliable scoring criteria. Assessment task creators look for two kinds of reliability. First, test developers and clinicians want to know that two people looking at the same kind of behavior, using the same scoring criteria, will see the claimant operating at the same level of performance. Also, other things being equal, test developers and clinicians want to see the same level of performance with claimants at two different times. Then, if the claimant shows different levels of performance at different times, clinicians will know that they are looking at salient changes in performance level. Test developers want to know that the tests they develop effectively meet performance criteria for salient dimensions. Lechner wants to be sure that Functional Capacity Evaluations will assess the claimant's ability to safely meet physical work requirements for different jobs.

*Psychological Factors Affecting Functional Capacity Evaluations*

There, as Hamlet says, is the rub. Lechner describes workers who may be slipping, but who still manage to do the jobs. One of us remembers an elderly janitor who could work his building. Developers tore it down, and his company transferred him to a new building. He could not do the work. He had marked troubles with memory and flexible thinking. The janitor had memorized the old building from

days building into months, and months building into years of repetitive work.

Lechner writes "One of the most difficult and controversial issues in administering FCEs involves determining the client's sincerity of effort during the evaluation." She writes that clinicians worry that workers' compensation claimants may trim their efforts in search of financial security. Lechner et al. (1994) write that claimants may also not do their best because they fear pain, fear reinjury, or feel depression. So, again, clinicians face the challenge of considering ways in which emotional processes may affect performance skill levels.

*Waddell's Signs*

Clinicians working in predominantly medical settings look to the kinds of behaviors they are likely to encounter in their daily round of clinical activities to help them assess patients' sincerity of effort. Waddell worked with patients experiencing lower back pain, so he did physical evaluations with people who experienced lower back pain, including some who said their pain kept them from working. Waddell believed he saw some signs that were "non-organic."<sup>11</sup> We present them in a tabular form that closely follows Lechner's (1998) presentation.

<b>Waddell's Non-Organic Signs</b>			
<b>Type of Sign</b>	<b>Specific Sign</b>	<b>Elicited By</b>	<b>Shown By</b>
1. Tenderness	A. Superficial	Examiner lightly pinches skin over the thoraco-lumbar region.	Patient reports tenderness over a wide area of "lumbar skin" that does not follow a "dermatonal distribution." <sup>12</sup>
	B. Deep signs of musculo-skeletal tenderness	Examiner applies deep pressure over the thoraco-lumbar region.	Patient reports tenderness over a wide area.
2. Simulation Test	A. Axial loading	While the patient stands, the examiner presses down on the top of his head.	Patient reports back pain, presumably secondary to this pressure.
	B. Rotation	The patient stands and the examiner rotates the shoulder and the pelvis as a unit.	Patient reports back pain, probably secondary to the rotation.
3. Distraction Test	Straight leg raise and flip test	The patient lies on his back on a firm surface. With his knee locked, he raises his leg. Then he sits up, with knee over the edge of the table, and with the knee locked, he extends and raises his leg.	The clinician may believe that the claimant does not follow expected physical evaluation results if he raises his leg higher on the second than the first test.
4. Regional Test	A. Muscle weakness not consistent with expected physical evaluation findings	The clinician conducts lower extremity muscle strength tests.	The patient shows "giving way" of muscle groups not consistent with expected action based on neurological knowledge of muscle groups.
	B. Sensory disturbances not consistent with expected physical evaluation findings	The clinician conducts light touch and light pin prick tests over the lower extremities.	"Diminished" sensation to light touch and pin prick. Patient shows "stocking pattern" diminished sensitivity that does not conform with neurological patterns.
5. Over-Reaction		Examiner observes during evaluation.	Over-reaction through verbalizations, facial expressions, muscular tension, tremors, sweating, faintness.

Waddell and others using his signs showed different success rates in showing inter-rater reliability. Waddell (1980) trained physicians to use his non-organic signs and reported 85% inter-rater reliability. Lechner (1998) reported that Korbon et al.<sup>13</sup> asked two physicians to rate patients independently. The physicians did so within a week of each other. The researchers did not think that they created adequate rates of inter-rater reliability for axial loading, trunk rotation, and behavioral over-reaction. Lechner writes that Spratt et al.<sup>14</sup> created standardized scoring systems for five of the eight Waddell-detailed signs. Also, they used an examiner and an observer to evaluate sign reliability. The researchers created intraclass correlations ranging from .78 to .97.

Lechner observes that physical factors can contribute to positive Waddell findings. She reports that claimants or examiners can inadvertently rotate the claimant's lumbar region during trunk rotation, creating discomfort. People who lie flat on their back have more limited range of motion for their legs than people who are sitting. People can vary substantially when reporting or reacting to perceived pain or discomfort.

Clinicians can use Waddell's signs and their modifications to learn whether patients show more than clearly established and localized signs of neurological distress. Still, Lechner worries that clinicians will believe that Waddell's signs are stand-alone physical examination-based signs of symptom magnification. Lechner reports that several of Waddell's signs improve with physical and surgical treatment. If they do, then Waddell's signs are less likely to be signs of troubles which the claimant wants

others to believe she or he has. Lechner cautions, as do we, that these signs are best used as cautionary prompts for further evaluation rather than as clear markers for symptom magnification or prevarication.

*The Minnesota Multiphasic Personality Inventory-2 (MMPI-2):*

We want to know symptoms that people report and whether reported symptoms match patterns shown by patients for physical ailments and mental and emotional disorders. Also, we want to know whether patients are being truthful. So, we use self-report inventories like the MMPI-2.

Using the MMPI-2 to assess neurologically toned difficulties presents challenges. Berry and Butcher (1998) described studies showing that people with physically toned difficulties are more likely to endorse items that cluster on the following scales.

**Scale 1 (the Hs. Scale):** This scale typically contains items describing physically toned symptoms. People with neurologically toned troubles have these symptoms.

**Scale 2 (the D Scale):** Scale items describe anxiety and depression. Patients may endorse these items because directly or indirectly their ailments create physiologically toned precursors of these emotional states and because people worry and feel discouraged when they are ill.

**Scale 3 (the Hy. Scale):** This scale has items reflecting feelings of physical discomfort.

**Scale 7 (the Pt. Scale):** Scale items show feelings of doubt and uncertainty that people have about themselves.

**Scale 8 (the Scz. Scale):** Scale items can reflect unusual perceptions and states of mind that people may experience.

Some psychologists want self-reporting scales to show mostly, if not only, signs of mental and emotional disorder. Perhaps to this end, researchers like Gass and Russell<sup>15</sup> asked board-certified neurologists to identify neurologically toned MMPI items. Through this screening Gass and Russell identified 42 items. Gass<sup>16</sup> picked 75 head-injured patients and compared their item endorsement with the MMPI-2 standardization sample. He found 23 items that neurological patients more consistently endorsed. Gass factor-analyzed these items and found 14 that he described as neurological complaints. Another five items characterized psychiatric complaints. Alfano et al.<sup>17</sup> asked 14 clinical neuroscientists to pick neurologically toned MMPI items. They then examined MMPI profiles of 102 moderate-to-severe head-injured patients. The researchers identified 24 items endorsed by 30% or more of the head-injured patients. Again, the researchers identified two factors. Thirteen items loaded on a factor they described as neurobehavioral and another 10 items loaded on a factor described as emotional somatic. Dunn and Lees-Haley<sup>18</sup> compared forensic head-injured patients with non-head-injured patients. They found only five MMPI items differentiated the two groups. Berry and Butcher also write that deleting neurocorrective factor items from MMPI protocols will purge self-report inventories of valuable information about how people with neurological troubles think and feel.

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*(Consistency, cont'd from Page 14)**Symptom Magnification and the MMPI*

Like the MMPI, the MMPI-2 has many scales assessing the client's potentials for over-reporting symptoms. Clinicians, like Lees-Haley et al.,<sup>19</sup> created scales that differentiate clients who over-report symptoms for gain from clients who do not. Following are MMPI-2 validity scales that help to differentiate symptom magnifiers from clients who respond appropriately to the MMPI-2.

**F (infrequency scale):** These are items that less than 10% of the standardization sample endorsed in the pathological direction.<sup>20</sup> Referring only to averaged group differences, the reviewers found that the F scale differentiated effectively between symptom magnifiers and clients who reported candidly. Clinicians do not want to confuse claimants who magnify their symptoms for gain with patients experiencing mental and emotional disorders. Greene<sup>21</sup> gives cut-off scores that reduce prospects of confusing patients with mental and emotional disorders with patients magnifying their symptoms.

**The Fb Scale:** This is a scale, new with the MMPI-2, that identifies unusual item endorsement for the last "half" of the MMPI scale. Rogers, Sewell and Salekin (1994) found that Fb-grouped response endorsement averages also differentiated symptom magnifiers from candid inventory reporters.

**F-K Differences:** We have already described the F scale. The MMPI and MMPI-2 K scale measures peoples' potentials for defensively underreporting personal difficulties. So, a large discrepancy between an F scale raw scores and a K scale raw score can be a mea-

sure of symptom magnification. Rogers et al. (1994) find that grouped averages of symptom magnifiers and candid reporters differ significantly. Patients with mental and emotional disorders may strongly endorse F scale items while "scaling down" on K scale items. So, Greene (1997) reports that researchers do not have clear guidelines to find cutoff scores that firmly differentiate patients from symptom magnifiers.

*Malingering with Head Injury*

Most of the MMPI-2 symptom magnification studies are general surveys that do not specifically address head-injured patients. Earlier, Bernad and Smothers (1999) described forced-choice symptom magnification. Clients who scored significantly below chance expectations on these tests presumably knew the right answer and deliberately picked the wrong answer to give the impression they had terrible memories.

Binder<sup>22</sup> compared 15 well-diagnosed head-injury patients with a group of 36 patients experiencing mild, uncomplicated head injury. He used the Portland Digit Recognition Test to divide the 36 patients into well-motivated patients (15) and poorly motivated patients (21) Binder got statistically significant differences for averaged F scale scores between the two groups. He also found a moderate correlation between F scale item endorsement, and parts of the test that he proposes may be more sensitive to symptom magnification.

Millis, Putnam and Adams<sup>23</sup> took 20 to 30 moderately to severely brain-damaged patients. They compared them with 20 mild uncomplicated head-injured patients who scored well below chance on a forced choice rec-

ognition test. They found that the F scale, the F-K differences and the Lees-Haley fake bad scale differentiated the two groups. Berry and Butcher (1998) wonder whether the MMPI may assess efforts to dissemble on "psychological variables," while forced choice recognition tests may tap a claimant's effort to show cognitive troubles. Still, we need to remind ourselves that many MMPI validity scales contain items that, when endorsed, could show the client to be severely mentally disturbed. Claimants who magnify head-injury symptoms for gain may be more interested in showing that they do not remember, or do not think clearly, than in showing they are psychotic. Still, we believe that we should be cautious about dividing assessment of symptom magnification into categories of psychopathology and troubled thinking as if life experiences have not intertwined the two. Attempts to separate the two processes as if they are not interrelated seems like repeating Descartes' differentiation between mind and body.

*Conclusion*

We wondered if we would find a gold standard that would let us differentiate between real and fabricated symptoms and a magic bullet that would help target the latter. We have not found any criteria that, on a stand-alone basis, differentiate symptom magnifiers from candid patients.

So, we turn back to conclusions we presented earlier. During our evaluations we may find hints and clues that lead us to question client response integrity. Still, we face an arduous series of tasks when we learn whether results we see are true or fabricated. Physicians look for internal consistencies and deviations in their physical examinations and neuroimaging diagnostic

tasks. All clinicians look to the client's reported history and contributory sources to see if stories presented make internal sense or contradict each other. Sometimes, during behavioral observations, we are lucky enough to see a blue elephant that throws client veracity into severe doubt. When conducting mental status evaluations and psychological evaluations we look for internal consistencies or substantial variances in the evaluation results we see. Clinicians, in medicine and psychology, have created scales and tests to help us assess the veracity of behaviors we see.

Though we look for consistencies and inconsistencies in our evaluations, we do not know that we have found falsification when evaluation results do not seem to jibe. When we see discrepancies, our clinical responsibilities empower us to explain them as best we can. If a client, across many dimensions, gives us results that do not go together, we are probably looking at the client's attempt to tell an untrue story. Even then, as clinicians we face the responsibility of describing these discrepancies, and learning why they happened.

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