Effective Use of Non-Physician Treaters

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Paper: Effective Use of Non Physician Treaters

After working for over 20 years as an occupational therapist, I recently switched to a new path, that of a legal career. During my short time viewing litigation from the legal side of the fence, I have been surprised by how lawyers view the role of treating health professionals and what types of information these professionals can bring to a case. The reader will note that this paper is devoid of legal case precedents or research study references. Rather, I am hoping that in sharing my perspective and experience, Plaintiff counsel can more effectively access and utilize the breadth of knowledge and information that treating professionals can provide.

In representing their clients, Plaintiff Lawyers often access the expertise of Physicians and Medical Specialists to conduct Diagnostic Testing, to conduct Independent Medical Assessments, and / or to provide Expert Witness Testimony. This Physician generated information is often viewed by the lawyer as highly valuable due to the "objective" nature of the information, combined with the high level of qualifications of the Expert.

In my experience, Lawyers often turn to Physicians and Specialists in search of Holy Grail of "objective" information, but this "objective" information is either glaringly obvious to everyone involved, or testing fails to identify the problems that result in subtle functional impairment. For example, although the finding of objective imaged evidence of a brain injury on an MRI is helpful to the case, what really matters is whether this translates into any functional impairment.

1. The Problem with Objective Information

In focusing on the home run "objective information", lawyers risk missing the valuable, albeit more subtle, qualitative data that actually has the most impact on the daily functioning of their client. It is this qualitative data that can be translated to actual cost items under the various heads of damage. An MRI showing a TBI will translate into very little in the way of a damage award, if the Plaintiff has little to no functional impairments. Conversely, even when an MRI fails to show a TBI, if the Plaintiff is demonstrating problems that can be remediated or minimized through the provision of future care items, the award can be substantial (see Wallman SCBC, 2013). This qualitative information, or what I would term "mixed objective/ subjective" data, can be obtained from non-physician treaters, particularly Allied Health Professionals ("Clinicians"). It is this mixed objective / subjective data that brings all the information together, and I would argue that this is often the most important information for proving your case.

Valuable lay witness information can also be obtained from direct care workers, co-workers, and the client's family. However, this lay witness evidence is subject to criticism for being too subjective and biased. Lawyers need to remember that

Clinicians do not understand "objective" in the same way that lawyers do. This is particularly the situation for Clinicians who are not actively seeking out "IME" or "expert witness" work.

For most Clinicians, particularly Occupational Therapists, "objective" information is actually the mixed objective / subjective information that is the product of hearing what the Client reports, observing what the Client can do, and applying clinical judgment to that information. This is why Lawyers become frustrated when they read charts that include statements such as "Joe is doing better"; this is the conclusion of the Clinician after considering that Joe said he is feeling better, providing treatment and observing that Joe's movement has indeed improved, and then synthesizing the information to conclude that indeed, Joe is "doing better".

2. Is this Clinician a Future Witness?

The first question a lawyer should ask herself when retaining or establishing a relationship with a treating Clinician is whether this individual may be called as a witness and be required to provide testimony in the future. Clinicians, particularly those working in the public realm, are not typically experienced with the courtroom setting, and are very anxious about the prospect.

When providing treatment to your client, the Clinician does not likely expect that he or she will be required to testify in the future. This lack of expectation, combined with the severe time pressures and limited resources within the public health system, can have an impact on the detail and quality of the charting completed with respect to your client.

The lawyer is well advised to have a discussion with the Clinician, early in the treatment process, to advise the Clinician that these matters do sometimes go to court. Do reassure the clinician that most cases do settle. During this discussion, it is important to provide positive encouragement to the Clinician to keep clear SOAP[i] (or similar type) notes, as the court will want to know what information in the notes is Subjective versus Objective information. Inform the Clinician that sometimes cases go to court and this can happen years later (when the Clinician's memory has faded), so clear differentiation of what the patient said, what the Clinician's Objective observations are, as well as the clinician's impressions (clinical judgment) are essential. Remind the Clinician that the goal is to ensure accuracy in the documentation of problems as well as documentation of progress/ improvement over time. Stress how helpful the documentation of concrete real life examples of functional problems can be for the injured person. Reassure the Clinician that if the matter does go to court, you will be there to provide guidance on how the court system and testimony work. Remember that most treating Clinicians are intimidated by Lawyers and are very anxious about the prospect of any type of court proceeding. Be courteous and respectful; Clinicians talk amongst themselves, to Physicians, and to Patients.

3. The Expertise Hierarchy

Based on my experience as a Clinician, issues arise when the Health Professional evaluating and /or providing treatment is too far removed from the patient. Specialist Physicians, who sit atop the Expertise Hierarchy, are both expensive and very busy. Although family physicians do have a bit more time for the patient, visits are usually confined to office contacts every few weeks. Consider how much time the Medical Specialist or GP actually spends with your Client over the period of several years.

It is only when the Patient encounters non-physician health care professionals, that significantly more time is actually spent with the individual. Time with the Patient provides the opportunity to observe multiple examples of functioning over time.

Due to cost containment measures within the public sector, as well as the private sector (such as ICBC funded rehab programs), it has been my experience that over the past 20 years there is increasing pressure to minimize direct Clinician contact. Instead, funders are increasingly looking to Clinicians to delegate treatment to Rehabilitation Assistants (RAs), Kinesiologist (KIN), Care Aides and family members. Occupational Therapists are increasingly taking on the more generic role of "Case Manager", which then limits their opportunity to observe the patient in real life settings.

As one moves up the Hierarchy of Expertise, the higher the cost for the assessment/ treatment typically becomes. The challenge is that RA, Care Aide, or KIN are cheaper than OT, PT or SLP, but they have less expertise, and the information gathered may be of little use for legal purposes.

If too much contact is delegated to the RA, Care Aide, KIN, or family, the problem emerges that the "objective" information becomes increasingly "subjective" and biased. The RA, Care Aide, or KIN may miss the important details or subtle impairments that an experienced Clinician, given sufficient time with the patient, will notice. The lay evidence RA, Care Aide, or KIN in court may not carry as much weight with the trier of fact, due to their limited education, expertise and potential bias if they get too close to the patient. For example, a Care Aide may become very comfortable with a Client over an extended period, and may be reluctant to acknowledge improvements in function that may lead to decreased work hours and pay. Family members or friends of the patient usually lack the medical knowledge necessary to back up claims that the patient is impaired, and they may also be seen as overly subjective.

As a lawyer, it is important to realize that treating Clinicians are key to providing you, and the court, with important information about your client, should the matter proceed to trial. It is also important to advocate for your client receiving direct treatment from a Clinician wherever possible. This is particularly important in the early stages of treatment, where changes can occur rapidly and the individual has

not yet plateaued. If you are retaining a Clinician to work with your client, it is appropriate to ask how much time the Clinician will actually spend with your client and how much delegation there typically is to support staff. In recent years, I have seen numerous examples of OTs who are contracting to ICBC inappropriately delegating clinical decision making to their support staff and /or provide insufficient monitoring of rehab programs.

3. Real World Application vs. Clinic Setting

Health Professionals can provide valuable practical solutions and observations of function. Functional impairments are what ultimately translate into increased damage awards you're your Plaintiff under non-pecuniary and pecuniary heads of damages. Skilled Clinicians should provide education and training to the Client on how incorporate compensatory strategies (physical, cognitive, energy conservation etc). If the Client is able to improve functional tolerances as a result, this looks favorable with respect to mitigation, effort and participation in rehabilitation. If the Client does not benefit from strategies, this strengthens the justification of future care to hire support services to assist with completion of the tasks or equipment items, and these problems can also be helpful in showing loss of enjoyment of life. By treating the Client in the real world setting, this provides practical examples of the match (or mismatch) between the diagnosis (provided by the Specialist Physician or Neuropsychologist) and the reality of daily life.

Through observations, the Clinician can determine:

- Can the individual perform specific tasks?
- Can the individual benefit from modifications?
- Are they compliant with treatment and strategies recommended?
- What is the impact of performing the task(s)? (such as increased pain, fatigue, increased symptoms, durability).
- Whether objective assessments (such as range of motion, muscle recruitment, and strength testing) match with objective observations and client report.

Within the Scope of Allied Health Professionals, assessment and treatment ranges from purely office based "objective" testing through to community based observational testing. For example, the Functional Capacity Evaluation (Physical and /or Cognitive) can be valuable in providing an "objective" clinic based assessment, but can be criticized for its lack of ecological validity, because it does not fully replicate the work site. Where your client has a unique work situation, a work site assessment can be of benefit in evaluating their specific job demands. Extended assessments that include community observations, particularly in the case of the cognitively impaired Client, can be extremely helpful. Rehab Companies are now offering extended assessments that go beyond the traditional clinic based FCE. I recommend ensuring that the Clinician provides a balanced approach, combining

objective testing (standardized assessments) along with home, community, and work observations wherever possible.

Be wary of reports or Clinician Assessments that are overly focused on "objective testing", and lack an analysis of the combined impact of objective testing, clinical observations, medical information review, and Client report. Wherever possible, get information about your Client's functioning, from an experienced clinician, based on first hand observation and testing, completed in a real life setting, over an extended period of time.

The utilization of non-Physician Treaters (Clinicians) can be cost effective and can provide powerful evidence of functional impairments, which ultimately translates into an increased award for the injured Plaintiff.

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[i] SOAP notes refer to a system of note taking that involves systematic recording of Subjective, Objective, Assessment, and Planning information on a patient chart.