

Overdiagnosis of Psychiatric Disability: Complaisance, Advocacy, Fraud or Ignorance?

Fabien Gagnon*

Forensic Psychiatrist, Quebec Medico-Legal Institute and Professor, Department of Psychiatry and Neurosciences, Université Laval, Quebec City, Canada

***Corresponding Author:** Fabien Gagnon, Forensic Psychiatrist, Quebec Medico-Legal Institute and Professor, Department of Psychiatry and Neurosciences, Université Laval, Quebec City, Canada.

Received: November 22, 2018; **Published:** January 29, 2019

Abstract

Increasing prevalence of work disability claims

Work disability is often a more complex phenomenon than it may look at first glance. In fact, work disability relates to the interaction of a multitude of systems like the workplace system, the legislative and insurance systems, the health care system and the employee's/worker's/claimant's/patient's personal coping system [1].

Keywords: *Overdiagnosis; Psychiatric Disability; Work disability*

Over the last twenty years we have been informed by the World Health Organization that there would be an increasing prevalence of depression in the general population [2]. Also, in the United States of America, the estimated lifetime prevalence of mental health disorders would be around 25% [3]. So, near to one quarter of the U.S. population will present a mental health disorder during his/her life. Of course, we know that depending on the measures used, the prevalence of mental health disorders may differ from one country to the other e.g. Statistics Canada (2013) evaluates the prevalence of mental health disorders in Canada at around 3,9 %. Also, Statistics Canada identified that with aging, there is an increasing prevalence of co-morbidity of mental disorders with physical disorders [4].

Not only can we notice an increase of mental health disorders but the US Social Security Administration [5] noticed that between 1961 and 2011 there was an increase from 9,6 to 19,2% of the prevalence of new workers disability claims. Accordingly, the OECD [6] identified a significant increase in the number of new worker disability claims in 9 European countries, from 1999 to 2009. These days, more and more workers work till they reach an older age with the accompanying progressive chronic disability [7]. So, physicians and other health professionals will eventually be more often confronted to the need to assess work disability.

As an independent medical examiner, I have noticed, like many of my colleagues doing Independent medical examinations (IMEs), that we often meet examinees who are put on sick leave by their treating physician, even though there is no medical evidence of total invalidity (which is the most frequent required condition to be accepted by collective insurance plans). We also often noticed that when the patient says he/she feels not ready to return to work (RTW) even for different non-medical reasons (e.g. problem with superiors or colleagues), they still are put on sick leave by their physicians. It then raises a simple question: How does the General Practitioners (GPs) evaluate their patient's disability?

We also often see situations where the RTW is postponed by a nurse practitioner or family medicine resident or another health professional, while on file the GP's documents are recommending RTW. Also, in many cases, the GP maintains the patient's disability leave

till he/she comes back from vacation, with or without a medical condition supporting the maintenance on sick leave during that period. Sometimes examinees also report that their GP said to him/her that he/she indicate that he/she will write “major depression” on the sick note, just to make sure the patient will receive insurance benefits. In other cases, the GP writes that he/she “feels” the patient work environment is toxic but, at the same time, gives 80% at Global Assessment of Functioning (DSM-IV-TR). There are even more similar reasons which again raise the initial question: How does the GPs (medically) evaluate their patient’s disability? Let us look at reasons for discrepancies in the diagnosis of sick leave for a mental health disorder.

Could the overdiagnosis of psychological disorders complicate the problem of work disability assessment?

With the publication of DSM-5, in 2013, many authors raised issues around psychiatric diagnosis. Among them, Dr. Joel Paris, from McGill University in Montreal, Canada, published an interesting book entitled “The intelligent clinician’s guide to the DSM-5” [8]. Like many other authors, he noticed that: often clinicians do not read the definition of mental disorder in the DSM (re: severity of symptoms); clinicians mostly use heuristics and rely on “impressions” and give a diagnosis not based on the specific DSM diagnostic criteria; normal reactions are then becoming “psychiatric”. So, he notices a trend toward overdiagnosis in psychiatry [9,10].

Increasing prevalence of depression

Rait [11] studied the potential factors explaining the reported increase of prevalence of depression in the UK. They demonstrated that clinicians most often do not use rigorously the classification diagnostic criteria, but rely on patient’s report of symptoms, which then gives a false impression of increased prevalence of depression.

Another aspect which may potentially influence the reported increase of work disability for mental health problems is that many mental health professionals often forget (or do not know how) to distinguish 3 distinct aspects of the alleged disability context: 1) the medical diagnosis; 2) handicap/functional limitations, 3) the definition of disability (which differs according to the insurance contract, the union agreement, etc).

So, many GPs do not distinguish psychiatric diagnosis from the diagnosis of psychiatric disability. Simply said, they do not do a specific disability assessment. In fact, disability assessment, or disability diagnosis, differs from the diagnosis of a mental disorder. Hence a patient with adjustment disorder may be totally invalid to work, while a patient with major depression may still be fit to work or not qualify to the clauses of an insurance contract for “disability”.

We must recognize that even for IME experts the diagnosis of work disability is not always easy (re: sources of variation causing low inter-rater reliability in medical evaluations [12]). It may be due to the interaction between expert and claimant, to experts obtaining different information as a result of asking different questions. There may be observation variance where experts differ in what they notice and remember when presented with the same information. There may be interpretation variance where experts differ in the importance they attach to what is observed. There may be criterion variance where experts use different criteria to score the same information. There may be variance between subject and within expert with claimant variance i.e. 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. There may be expert variance where 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. Also, experts may differ in their personal value system on what level of effort, endurance, and discomfort can reasonably be expected by a claimant. Finally, experts may differ in their understanding of the legal requirements on a medical expertise that could affect their medical judgment.

But, let us go back to 3 common sources of variances explaining the trend by clinicians to more easily give work disability diagnosis: 1) sympathy bias can be described by the position of the physician who is in a helping relationship and wants the best for his/her patient,

but do not specifically look for other factors which may influence the patient's report; 2) patient advocacy role where the clinician feel sorry for a patient's difficult situation as reported by the patient; 3) good medicine perception (therapeutic bias?) where the physician spontaneously wants to protect his/her patient, even though they only have one version of the facts.

To decrease those sources of variance, physicians could try strive toward an objective and comprehensive assessment and management of the patient's condition with detailed evaluation of the patient's functioning in different situations (at home, at work, in social situations) with collateral information and do a comparative functional assessment after obtaining the evaluatee's job description.

Overdiagnosis, or mis-diagnosis, of mental health disability: How should we deal with it?

Since overdiagnosis, or at least mis-diagnosis, of mental health disability likely exists, how should we consider the situation? How should we deal with it? Is it "complaisance" i.e. does it relate to the situation where the physician writes unverified information, without a rigorous medical examination which supports disability, simply because the physician wants to help his patient and take side. That situation is often referred in the literature as "Gaming the System".

Is this a form of fraud? Should physicians filling disability notes without medical evidence be civilly sued, since someone else pays for the patient's sick leave? Should the physician be sued professionally? Or, is all this a simple question of ignorance?

Experience shows that suing is time consuming, costly, and does not have a large impact on the general practice of clinicians [13,14]. If we approach the over- or mis-diagnosis of work disability assessment as simple ignorance, we can consider that when a physician writes a sick note, he/she may not realize that he/she declares that, according to his/her objective medical assessment, the patient has a medical condition supporting work disability. Do treating physicians really know the impacts of the sick note they have signed. Do clinicians really give an "informed medical opinion?"

According to some authors, the problem is not new one. For example, Dr. Liza Gold, a well-known American forensic psychiatrist wrote, already in 2009, about the "Gap in Mental Health Disability Evaluations", reporting: 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 [15-36].

Conclusion

Over the last thirty years there has been an observed major increase of psychiatric diagnosis and of psychiatric work disability.

The issue of overdiagnosis of work disability and the reasons behind that situation also raise some ethical issues. Does a treating physician have a duty only to the patient, or also a duty to the profession, a duty to society, since someone will pay for it?

Like numerous authors, I strongly believe that it is important to prevent the risk of mis- or over-diagnosis of work disability, and that investing into the education of medical students and physicians on disability issues is a must.

Bibliography

1. Loisel P., *et al.* "Prevention of Work Disability Due to Musculoskeletal Disorders: The Challenge of Implementing Evidence". *Journal of Occupational Rehabilitation* 15.4 (2005): 507-524.
2. World Health Organization. "The Global Burden of Disease 2004 update" (2008).
3. Kessler RC., *et al.* "Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative". *World Psychiatry* 6.3 (2007): 168-176.

4. Statistics Canada. "Canadian Community Health Survey (CCHS) - Mental Health, 2012" (2013).
5. Joffe-Walt C. "Unfit for Work. The startling rise of disability in America". National Public Radio (NPR) (2013).
6. OECD. "Sickness, Disability and Work: Breaking the Barriers". OECD Publishing (2010).
7. Westendorp RGJ. "What is healthy aging in the 21st century?" *American Journal of Clinical Nutrition* 83.2 (2006): 404S-409S.
8. Paris J. "Intelligent Clinician's Guide to the DSM-5". Oxford UP (2015).
9. Paris J. "Fads and Fallacies in Psychiatry". London: RCPsych Publications (2013).
10. Paris J. "Overdiagnosis in Psychiatry: How Modern Psychiatry Lost Its Way While Creating a Diagnosis for Almost All of Life's Misfortunes". Oxford: Oxford UP (2015).
11. Rait G., *et al.* "Recent trends in the incidence of recorded depression in primary care". *The British Journal of Psychiatry* 195.6 (2009): 520-524.
12. Barth J., *et al.* "Inter-rater agreement in evaluation of disability: systematic review of reproducibility studies". *British Medical Journal* 356 (2017): j14.
13. Cunningham W and Dovey SM. "The effect on medical practice of disciplinary complaints: potentially negative for patient care". *New Zealand Medical Journal* 113.1121 (2000): 464-467.
14. Cunningham W and Dovey SM. "Defensive changes in medical practice and the complaints process: a qualitative study of New Zealand doctors". *New Zealand Medical Journal* 119.1244 (2006): U2283.
15. Bolderson H., *et al.* "Definitions of disability in Europe: A Comparative analysis: Final report". Tilburg University (2002).
16. Canadian Medical Association. "Third-party Forms: The Physician's Role" (2010).
17. Canadian Medical Association. "The Treating Physician's Role in Helping Patients Return to Work After an Illness or Injury (Update 2013)". CMA Policy (2017).
18. Canadian Medical Association. "Third-party Forms: The Physician's Role (Update 2010)". CMA Policy (2017).
19. Carter SM. "Overdiagnosis: An Important Issue that Demands Rigour and Precision". *International Journal of Health Policy and Management* 6.10 (2017): 611-613.
20. de Boer W., *et al.* "Medico-legal reasoning in disability assessment: a focus group and validation study". *BMC Public Health* 8 (2008): 335.
21. de Boer W., *et al.* "Organisation de l'évaluation de l'incapacité au travail dans 15 pays". *Pratiques et Organization des Soins* 38.3 (2007): 205-217.
22. De Wind A., *et al.* "The role of European physicians in the assessment of work disability: A comparative study". *Edorium Journal of Disability and Rehabilitation* 2 (2016): 78-87.
23. Gold LH., *et al.* "AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability". *The Journal of the American Academy of Psychiatry and the Law* 36.4 (2008): S3-S50.

24. Gold LH and Shuman DW. "Evaluating Mental Health Disability In The Workplace, Model, Process, And Analysis". New York, NY: Springer (2009).
25. Government of Canada. "How to Build a Disability Management Program: The Steps" (2017).
26. Maness DL and Khan M. "Disability Evaluations: More Than Completing a Form". *American Family Physician* 91.2 (2015): 102-109.
27. Minihan PM., *et al.* "Teaching About Disability: Involving Patients with Disabilities as Medical Educators". *Disability Studies Quarterly* 24.4 (2004).
28. O'Fallon E and Hillson S. "Physician Discomfort and Variability with Disability Assessments". *Journal of General Internal Medicine* 20.9 (2005): 852-854.
29. Physician Education Project in Workplace Health. "Injury/Illness and Return to Work/Function". PEPWH (2000).
30. PLOS Medicine Editors. "The Paradox of Mental Health: Over-Treatment and Under-Recognition". *PLoS Medicine* 10.5 (2013): e1001456.
31. Pransky G., *et al.* "Improving the physician role in evaluating work ability and managing disability: a survey of primary care practitioners". *Disability and Rehabilitation* 24.16 (2002): 867-874.
32. Regis C. "Physicians Gaming the System: Modern-Day Robin Hood?" *Health Law Review* 13.1 (2004): 19-24.
33. Russell G., *et al.* "Managing injured workers Family physicians' experiences". *Canadian Family Physician* 51 (2005): 78-79.
34. Soklaridis S., *et al.* "'Can you go back to work?' Family physicians' experiences with assessing patients' functional ability to return to work". *Canadian Family Physician* 57.2 (2011): 202-209.
35. Taiwo OA and Cantley L. "Impairment and Disability Evaluation: The Role of the Family Physician". *American Family Physician* 77.12 (2008): 1689-1693.
36. van Rijssen J., *et al.* "Communication skills training for physicians performing work disability assessments increases knowledge and self-efficacy: results of a randomised controlled trial". *Disability and Rehabilitation* 21 (2015): 1-9.

Volume 8 Issue 2 February 2019

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