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Civil Forensics: Ability vs. Disability Management

Two honest psychiatrists, the same file, opposite conclusions — and how to keep the system's context from bending your judgment.

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CONTINUING MEDICAL EDUCATION

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WHAT YOU'LL LEAVE WITH

Three promises

01 **Manage the request you dread** what to do when a patient asks you to certify disability — without wearing two hats at once.

02 **Read the system you're standing in** how FMLA, workers' comp, STD/LTD, SSDI and the VA each define 'disability' differently — and how that bends the opinion.

03 **See the context before it bends you** how referral source and incentives shape the formulation — and the ethics safeguards that keep you honest.

And one larger claim: psychiatry is a medico-legal profession — our diagnoses are legal facts — and we must reclaim the body we stopped examining.

Manchester, New Hampshire, 1926

My grandfather died at work.

New Hampshire had a workers' comp law in 1911 — but it was **elective**. If the employer hadn't opted in, the widow's only recourse was to **sue for negligence** — slow, uncertain, often worth nothing. The family went back to Poland.

That gap — between getting hurt and getting made whole — is the problem every system in this talk was built to close.

THE LONG ARC

Insurance is just organized risk-pooling

~1750 BCE	Hammurabi — 'bottomry,' a precursor to insurance (ship loans forgiven if the cargo is lost)
1688	Lloyd's of London — merchants pool marine risk over coffee
1883–84	Bismarck's Germany — the first national sickness & accident insurance
1911 / 1913	Wisconsin, then Texas — U.S. workers' compensation
1943 / 1954	War wage controls + the tax code tie health insurance to the job
1956 on	SSDI, Medicare/Medicaid, SSI, ERISA, ADA, FMLA, ACA

WORKERS' COMPENSATION

The grand bargain

Germany, 1884. Industry needed to grow without being bankrupted by lawsuits, workers needed to survive being maimed, and Bismarck wanted to undercut the socialists.

THE WORKER

Gives up: the right to sue the employer.

Gets: no-fault coverage — medical care + wage replacement, no need to prove blame.

THE EMPLOYER

Gives up: the courtroom defenses that used to win.

Gets: immunity from negligence suits + predictable, insurable cost.

The catch for us: once blame is off the table, the fight moves to a medical question — how hurt, how long, how disabled. That question lands on your desk.

TEXAS, SPECIFICALLY

How our system got the shape it has

1913	Texas adopts WC — uniquely ELECTIVE (the 'non-subscriber' option survives to today)
1989	Senate Bill 1 — creates the Texas Workers' Compensation Commission (TWCC)
2005	House Bill 7 — abolishes TWCC → DWC inside TDI, adds OIEC, builds WC networks 'similar to group health'
2007	ODG takes effect for treatment; care outside it requires preauthorization (May 1)

NOT THE MEDICINE YOU THINK YOU KNOW

Comp care is a different animal

Who's in charge

In Texas WC, chiropractic had outsized control of the care pathway; psychologists are pushing for 'treating physician' status — and, ultimately, prescribing.

What the goal is

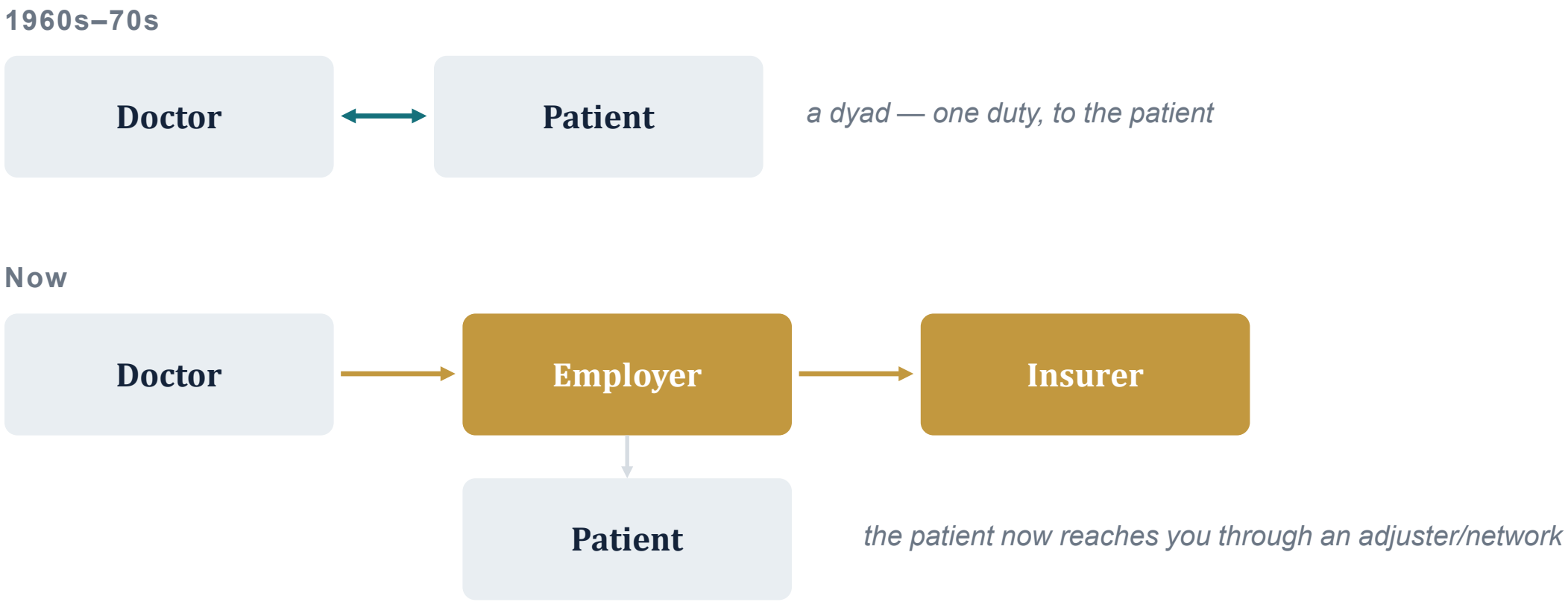
Group health asks 'is it medically necessary?' Comp asks 'when does function return for work?' (treatment) Different question, different answer.

Who's at the table

The visit is no longer you and the patient. It's you, the employer, and the insurer — with the patient on the far side of an adjuster.

THE STRUCTURAL SHIFT

Who is actually in the room



THE ETHICS CREDIT, EARNED

Ethics, morality, professional ethics

Morality	Your personal sense of right and wrong. Real, but private — it is not a license to override the rules of the role.
Ethics	Reasoned principles you can defend to others — beneficence, autonomy, justice, truth-telling.
Professional ethics	The duties the role imposes, which can differ from both. The examiner's first duty is to truth, not to treatment.

THE CENTRAL ETHICAL TRAP

You cannot wear two hats at once

TREATING — the healer's hat

Duty: the patient's welfare.
Stance: trust, advocacy, benefit of the doubt.
Confidentiality protects the alliance.

EXAMINING — the forensic hat

Duty: truth, to a third party.
Stance: neutral, skeptical, verify.
No treatment alliance to protect — and you must say so up front.

The breach is wearing both at once: treating your own patient and then writing their disability opinion. The duties conflict; the role you owe is the one that pays — so you owe the patient a clean answer/referral, not a double role.

THE OBJECTION YOU WILL GET

“Doesn't examiner work break the Hippocratic oath?”

The honest answer, said plainly:

- The examiner isn't the treater. 'First, do no harm' governs a treatment relationship you never entered — and you say so before the exam begins.
- An honest exam doesn't deny care; it answers a question the system must answer anyway. A dishonest one harms everyone who isn't lying.
- Truth-telling is itself a medical virtue. The duty didn't vanish — it changed objects: from this patient's wishes to the accuracy the third party relies on. Lead by example.

WHY TWO HONEST DOCTORS DISAGREE

Context bends judgment — measurably

Adversarial allegiance	Experts drift toward whoever retained them — shown in a randomized experiment on sex-offender risk scoring (Murrie), not just anecdote.
Cognitive bias	Expectations and the order you learn facts shape what you 'see.' Domain expertise does not immunize you.
Secondary gain ≠ malingering	Compensation context moderately worsens measured outcomes; outright malingering is real but far rarer than assumed. Contextual bias.
Debiasing is a discipline	Blind to irrelevant context, specify criteria before you look, document the reasoning — not just the conclusion.

Bias starts before anyone retains you

Anchoring	The first diagnosis or number you read (referral letter, prior IME) sets the frame; later data get adjusted from it instead of weighed fresh.
Confirmation bias	You seek and overweight data that fit the working hypothesis and explain away results that don't. Write down what would change your mind.
Diagnosis momentum	A label in the records ('malingerer', 'TBI', 'PTSD') travels from chart to chart and closes the search for alternatives (premature closure).
Hindsight and outcome bias	Knowing how things turned out (a claim, a lawsuit, a bad outcome) makes the earlier course look predictable and the earlier care look negligent.

The adversarial process adds biases you never chose

Adversarial allegiance	Opinions drift toward the side that retained you, even among experts who believe they are neutral and score the same file (Murrie, 2013).
Contextual bias	Task-irrelevant information (the attorney's cover letter, the claim amount, prior opinions) changes how the same data are read (Dror).
Narrative rehearsal	A claimant retells the injury to adjusters, attorneys and examiners; each retelling reshapes memory and fixes attributions, so the story firms up while accuracy does not.
Role bias (treating source)	Wanting to help your own patient pulls a factual report toward advocacy; the alliance you need clinically is a bias forensically (Strasburger, 1997).

The data reach you already filtered

Selection (referral) bias	IMEs see disputed claims; clinics see help-seekers; studies enroll whoever volunteered. 'What I usually see' describes your referral stream, not the condition.
Base-rate neglect	A test result means little without the prevalence in that setting: a failed validity test predicts differently where exaggeration is rare than where it is common.
Recall bias ('good old days')	After an injury, people rate their pre-injury functioning better than population norms, which inflates the apparent change (Gunstad & Suhr, 2001).
Expectation (diagnosis threat)	Telling someone with mild head injury that they may have cognitive deficits lowers their test scores (Suhr & Gunstad, 2002). The evaluation itself shapes the data.

THE UNIFYING IDEA

It's one machine, wearing different badges

Workers' comp is the detailed case. But FMLA, STD, LTD, SSDI and the VA all run the same three parts:

1

A payer with a stake

an employer or insurer who pays if you're disabled

2

An evidence-based benchmark

a published expected duration / return-to-work guideline

3

An adversarial review

someone whose job is to flag any deviation from it

Learn the machine once, and you can read any request the patient/examinee walks in with.

THE TELL

One publisher. Two 'evidence-based' answers.

The same company, Hearst/MCG, publishes BOTH **MCG** (group-health 'medical necessity') AND **ODG** (comp treatment guidelines). The output is engineered to the context that pays for it.

47%	higher lumbar-fusion rate in California comp than in Washington, with about 2.3 times the reoperation risk (association; Martin et al., 2014)
64–82%	Texas ODG closed formulary: not-recommended drug costs down 82%; not-recommended opioid prescriptions down 64%; all opioid prescriptions down 11% (new claims, 2011 vs 2010; TDI, 2014)
+9–14 days	more disability days at one-year follow-up, associated with early, non-indicated MRI for acute low-back pain (Shraim, 2021)

SAME PATIENT, THREE 'EVIDENCE-BASED' ANSWERS

One veteran with PTSD

Specialty care (VA/DoD 2023; American Psychological Association 2025)

Full trauma-focused course: prolonged exposure or CPT, 8–15 sessions. Goal: recovery.

Workers' comp (ODG)

~12-session cycles gated on measured functional gain + return to work; non-response → change the plan.

Commercial plan (InterQual/MCG)

Authorized against 'medical necessity' — session by session, utilization-reviewed.

Same diagnosis, same evidence base — three different 'right' answers, because three different systems are asking.

WHEN THE MANUAL ITSELF SHOWS THE BIAS

PTSD Criterion A4

DSM-5, verbatim:

> *"Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related."*

The same aversive footage is **trauma if you were paid to watch it**, and not trauma if you weren't. That line has no psychological meaning and no physiological meaning — only a **legal / compensation** one.

THE WORDS HAVE CONSEQUENCES

From 'imbecility' to a diagnosis

Before (until 2023)

“a physically traumatic injury to the brain resulting in incurable insanity or imbecility”

After (HB 2468, 2023)

“a permanent major neurocognitive disorder” — determined using evidence-based medicine, with functional tests for supervision and employability.

Texas Labor Code §408.161(a)(6) — Lifetime Income Benefits. The statute says 'evidence-based medicine,' not 'DSM-5.' You supply the medicine the law now points to.

THE WORDS HAVE CONSEQUENCES

Over a century to change the words

1913 — the original Texas statute

"…a physically traumatic injury to the brain resulting in incurable insanity or imbecility"

2023 — HB 2468

"…a permanent major neurocognitive disorder" — determined using evidence-based medicine, with functional tests.

110 years

between those two sentences — from the 1913 statute to HB 2468, effective Sept 1, 2023.

The TSPP Forensic Committee had a hand in finally changing it.

OBJECTIVE 1 · THE MOMENT

When your patient asks you to certify disability

1 **Name the hat out loud —** 'I'm your treating doctor; a disability opinion needs a neutral examiner. Here's why, and here's how I can still help.'

2 **Document function, not just diagnosis —** What they can and can't do, with evidence — a diagnosis is not an impairment, and an impairment is not a disability.

3 **Protect the alliance —** Declining the forensic role is not abandoning the patient; a clean referral is the care.

4 **Set recovery expectations early —** Expectation of return is one of the few psychosocial factors that actually predicts outcome — shape it on day one.

The form on your desk

A patient hands you a disability form — the WC work-status report (DWC-73), an FMLA certification, an attending-physician statement. You are the treating doctor, not the examiner.

NAME THE HAT

This is a **treating opinion** — say so, on the form and out loud.

It is shaped by the alliance: that is **advocacy bias**. Not a defect — it's the role.

It is NOT a neutral forensic opinion. The neutral call is the Designated Doctor's / IME's job.

HOW TO HANDLE IT

1. Base restrictions on function and objective findings — not the patient's request.
2. Separate what you observed from what the patient reported.
3. Rate what you can; defer the rest to an FCE/ Neuropsychiatric measures a Designated Doctor/IME etc.
4. Document it as a treating opinion — don't dress it up as independent or objective.

Fill it out honestly as the treating doctor, labeled as such. The neutral opinion belongs to someone wearing the other hat.

OBJECTIVE 2 · THE BADGES

'Disability' means five different things

FMLA	a 'serious health condition' that stops you doing the job's essential functions — unpaid, job-protected leave.
Workers' comp	Texas: 'the inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage' (Labor Code §401.011(16)).
STD / LTD (ERISA)	the plan's own definition — 'own occupation' then often 'any occupation'; the contract controls.
SSDI / SSI	inability to do ANY substantial gainful activity, expected to last ≥12 months — the strictest bar.
VA / DBA / DOL	VA: service-connected conditions rated on the VA rating schedule. DBA (administered by DOL): lost wage-earning capacity from an overseas contract-work injury.

THE CLINICAL STAKES

Signing someone off is a medical act — with a dose

Worklessness and health: unemployment is associated with 2–3 times the risk of poor health and 20% excess deaths, though health selection confounds part of this (AFOEM, 2010).

The window is real — Return-to-work probability falls steeply with time off — roughly half by ~45 days out. Early matters.

Off the rolls is rare — Under 1% of SSDI beneficiaries leave the rolls for work in a year (0.8% in 2024); 3.7% of the 1996 cohort left for work over ten years.

But support works — Supported employment (IPS) roughly doubles competitive employment vs usual care (Modini 2016: RR 2.40; Bond 2012: 56% vs 23%).

BUT BE PRECISE

It isn't work — it's good work

Employment and home ownership aren't automatically protective. What actually moves mental health:

Job quality

control, fairness, effort-reward balance — a bad job can be worse than no job

Income adequacy

cash reduces distress most for those lifted out of poverty; the effect on clinical depression is real but modest

Security & stability

predictability of work and housing beats the raw fact of having either

So 'get back to work' is not the prescription. 'Get back to the right work, with support' is.

THE REAL THESIS

Psychiatry is a medico-legal profession

Our diagnoses function as legal facts — **competency, insanity, disability, commitment.** No specialty is more deeply fused with the law.

And the A4 line proved the other half: **we have vacated the physiological ground too.** If psychiatry won't own the law AND the body, both get taken from us — prescribing psychologists, scope creep, cannibalization.

Reclaim both: the medico-legal craft, and the physiology. It's one argument — the same one as the peptide talk.

WHAT I'M ASKING OF THIS ROOM

Three things to take back

1 **Keep the hats separate**

Know which role you're in before you write a word — and tell the examinee/patient.

2 **Read the badge, speak its language**

Match your opinion to the system that's actually asking; don't let one system's rules masquerade as 'the medicine.'

3 **Reclaim the ground**

Do honest examiner work without guilt — and take back the body and the law that are already ours.

SOURCES

Selected sources

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The historical trajectory

1884	Bismarck — the first national accident insurance (Germany)
1911	Wisconsin — the first U.S. workers' compensation
1913	Texas workers' comp — and the “insanity or imbecility” brain-injury standard
1916	FECA — federal workers' compensation
1956	SSDI — federal disability insurance
1974	ERISA — governs STD / LTD plans
1990	ADA — a civil-rights frame for disability
1993	FMLA — job-protected medical leave
2023	**HB 2468 — Texas modernizes that brain-injury standard, 110 years later**