ANTI-BIAS TRAINING

RECOGNIZING AND REDUCING BIAS IN QME EVALUATIONS AND REPORTS



PERRY J. CARPENTER, DC, QME
EZ CONTINUING EDUCATION
800-676-8127

THE REGULATIONS

- 8 CCR § 11(h): At least two hours of anti-bias training before initial QME appointment.
- 8 CCR § 11.5(i)(4): At least two hours within the report-writing course.
- 8 CCR § 55.1(b)(3): At least two hours for QME reappointment.
- THIS HOUR FOCUSES ON § 11(H)(1).



WHAT SECTION 11(H)(1) REQUIRES

- Instruction designed to increase awareness and understanding of differences in human experience,
- as well as awareness of implicit or unconscious bias, stereotyping, and discrimination,
- and the ways in which unconscious bias can unintentionally impact perceptions and decision-making, including in medical evaluations and reporting,
- and lead to disparities in health care strategies, to help eliminate or reduce implicit bias in medical evaluations and reporting.



BIAS, STEREOTYPE, AND DISCRIMINATION

- Bias: a tendency that tilts judgment. The QME expects exaggeration and gives inconsistent answers more weight than consistent findings.
- Stereotype: an assumption about a person based on a group. The QME assumes that older examinees describe pain less accurately.
- Discrimination: different treatment based on a group assumption. The QME gives a examinee who uses an interpreter less time to describe the injury.



CONSCIOUS AND UNCONSCIOUS BIAS

- Bias can reflect a stated belief or an unnoticed assumption.
- A QME unconsciously believes older examinees usually exaggerate symptoms and asks fewer questions about their work duties.
- A QME unconsciously believes a fluent examinee's account readily but challenges the same account from an examinee who uses an interpreter.
- A QME may intend to be fair and still reach a conclusion that reflects bias.



THE FIRST IMPRESSION

- A examinee arrives late and struggles to describe the injury. The QME questions the examinee's sincerity.
- Transportation problems may explain lateness. Anxiety or language barriers may affect the history.
- Pain, poor sleep, or medication may affect recall.
- Treat the first impression as an observation. Check it against the history, examination findings, and medical records.





BIAS IN THE QME EXAMINATION

The five bold entries at the end are the focus of the main discussion.

- Primacy / recency effects
- Overconfidence effect
- Fundamental attribution error
- Authority bias
- Hindsight bias
- Availability bias / salience
- Outcome bias
- Fallacy of the single cause
- Framing
- Base-rate neglect
- Self-serving bias
- Liking bias
- Information bias
- **Confirmation Bias**
- **In-Group/Out-Group Bias**
- **Halo Effect**
- **Story Bias and False Causality**
- **Anchoring**



Source: Rolf Dobelli, The Art of Thinking Clearly. QME applications by P. J. Carpenter.

CONFIRMATION BIAS

A QME may favor evidence that supports their early opinion.

- The QME suspects exaggeration and records inconsistent answers. The QME overlooks consistent findings.
- The QME expects an industrial injury and emphasizes work duties. The QME skips the history of prior symptoms/injury/treatment.
- The QME expects "degenerative changes" to explain the symptoms and gives little attention to the examinee's report of work exposure.



CONFIRMATION BIAS IN THE REVIEW OF RECORDS

A pre-conceived explanation can shape how the QME reads the record.

- A new record documents symptoms before the claimed injury. The QME dismisses it because it conflicts with the first opinion.
- The QME quotes normal findings from several visits but omits an abnormal examination that supports the examinee's account.
- The QME searches for prior injuries only after deciding that the current disability must be nonindustrial.



THE CHECK FOR CONFIRMATION BIAS

Ask what evidence would change the opinion.

- State the main explanation and at least one reasonable alternative.
- Identify evidence that supports and challenges each explanation.
- Ask the examinee questions that could prove or disprove the two explanations.
- Explain why a conflicting medical record does or does not change the opinion.



IN-GROUP AND OUT-GROUP BIAS

Shared and common backgrounds can influence trust and attention.

- A examinee shares the QME's hometown. The QME asks friendly follow-up questions and allows extra time.
- A examinee has an unfamiliar and difficult to understand accent. The QME asks fewer questions about the injury.
- A examinee shares the QME's profession. The QME accepts the examinee's descriptions of job demands with less scrutiny.

GROUP BIAS IN THE QME EXAMINATION

Different treatment can affect the history and the resulting opinion.

- The QME explains questions carefully to a familiar examinee but treats another examinee's "apparent confusion" as evasiveness.
- The QME interprets limited eye contact as a finding for dishonesty, without asking the examinee about anxiety or cultural expectations.
- The QME trusts a familiar colleague's medical report more readily than an equally supported report from an unfamiliar author.

THE CHECK FOR GROUP BIAS

Use the same standards for all examinees, and provide the support each needs.

- Ask every examinee the same core questions about the injury, the work duties, any prior symptoms, and activities of daily living.
- Use the interpreter as necessary. Confirm that the examinee understands the question.
- Allow each examinee to clarify an answer, or to correct the history.
- For ROR, assess each report by its findings and reasoning, rather than by your familiarity with the author.

HALO EFFECT

One trait can influence judgments about unrelated issues.

- A well-dressed examinee speaks confidently. The QME accepts the history before checking the records.
- The examinee struggles with medical terms. The QME assumes the examinee cannot give a reliable history.
- An examinee acts politely. The QME gives an inconsistent account less scrutiny.



THE HALO EFFECT IN PRACTICE

A favorable or unfavorable impression can spread to the medical opinion.

- An examinee appears physically fit. The QME assumes that the examinee has no meaningful impairment.
- An examinee describes delayed medical treatment, or lack of medical treatment. The QME assumes that the examinee's symptoms lack credibility.
- A examinee gives precise dates. The QME treats that precision as proof that the mechanism of injury as described by the examinee caused the condition.

THE CHECK FOR THE HALO EFFECT

Assess each medical conclusion on its own evidence.

- Describe the examinee's appearance and behavior as observations.
- Compare the history with the medical records, and the examination findings.
- Assess causation, impairment, and work capacity separately.
- Ask yourself whether your opinion would change if the examinee dressed or spoke differently.

STORY BIAS AND FALSE CAUSALITY

A coherent story or a sequence of events can seem to prove causation.

- An examinee gives a very detailed story about the injury. The earliest records describe a different story, but the QME accepts the examinee's story.
- Pain starts after a job change. The QME attributes it to the new work without examining other explanations for the pain.
- An examinee improves after treatment. The QME treats that improvement as proof of the original diagnosis.

WHEN A STORY BECOMES A CAUSE

Timing and plausibility need support from the medical evidence.

- An examinee first describes symptoms after a "difficult shift at work." The QME concludes that the shift caused the underlying condition.
- A prior injury appears in the record. The QME assumes that it explains the current disability without comparing the affected body parts or findings.
- Several events fit a persuasive narrative. The QME overlooks records that interrupt the proposed sequence.

THE CHECK FOR A CAUSAL STORY

Separate what happened (the story) from why or how the condition developed.

- Build the chronology from the dated medical records and the examinee's account.
- Compare the mechanism of injury with the diagnosis and examination findings.
- Consider other causes and explain why or how the evidence favors one explanation over another.
- Explain what the timing supports, and what remains uncertain.



ANCHORING

The first diagnosis, opinion, or number can become a reference point.

- The PTP’s prior report assigns 10% WPI. The QME starts with that number in mind before calculating the current findings.
- A cover letter calls the injury "minor." The QME views later symptoms through that description.
- The first diagnosis is a "strain." The QME gives little attention to later neurological findings.

ANCHORING IN RATINGS AND OPINIONS

An early reference point can limit an independent assessment.

- A prior report proposes 50% apportionment to be due to the industrial injury. The QME adjusts that percentage slightly without developing an independent explanation.
- An early medical record describes "mild pain." The QME gives later descriptions of multiple functional limitations little weight.
- An attorney suggests a diagnosis. The QME organizes the examination around that particular diagnosis, and overlooks another reasonable diagnosis.

THE CHECK FOR ANCHORING

Reach an independent opinion from the current evidence.

- Record the relevant history and findings before providing your rating.
- Calculate impairment from the applicable criteria and your measurements.
- Explain causation and apportionment from the evidence in this case.
- Compare your independent results with those derived from prior opinions and explain any differences.

FRAMING AND AUTHORITY BIAS

Wording and professional status can influence judgment.

- Framing: A description can shape the QME's response.
- QME example: A letter calls the examinee a benefit seeker. The QME starts with questions about motivation instead of the injury history.
- Authority bias: An author's status can overshadow the evidence.
- QME example: The QME repeats a respected surgeon's causation opinion without examining an unexplained gap in the chronology.

AVAILABILITY AND ATTRIBUTION ERROR

Memorable cases and assumptions about character can distort an assessment.

- Availability / salience: A memorable case or striking detail receives too much weight.
- QME example: A recent case of exaggeration leads the QME to interpret another examinee's variable findings the same way.
- Fundamental attribution error: The QME assigns behavior to character before examining circumstances.
- QME example: The QME assumes that missed therapy reflects poor motivation before checking authorization records.

OVERCONFIDENCE AND HINDSIGHT BIAS

Certainty can exceed what the evidence supports.

- Overconfidence: The QME has more confidence in an opinion than the evidence warrants.
- QME example: The QME gives a firm diagnosis after a limited examination and does not address conflicting findings.
- Hindsight bias: A known outcome makes an earlier event seem more predictable.
- QME example: A later diagnosis leads the QME to assume that the early symptoms clearly established that diagnosis.

OUTCOME BIAS AND THE SINGLE CAUSE

An outcome or one explanation can overshadow the full evidence.

- Outcome bias: The result determines how the QME judges an earlier decision.
- QME example: A poor surgical result leads the QME to assume that the original diagnosis lacked support.
- Fallacy of the single cause: One factor becomes the explanation for a condition with several possible causes.
- QME example: The QME attributes all shoulder symptoms to age without assessing work exposure or the reported incident.

BASE RATES AND INFORMATION BIAS

Background frequency and additional data require careful interpretation.

- Base-rate neglect: The QME overlooks how common a finding is in the relevant population.
- QME example: The QME treats a degenerative imaging finding as conclusive without considering its frequency in people without symptoms.
- Information bias: More information seems useful even when it does not answer the medical question.
- QME example: The QME orders another study without explaining how its result could change the opinion.

SELF-SERVING BIAS AND LIKING BIAS

Personal interests and rapport can influence how the QME weighs evidence.

- Self-serving bias: The QME interprets evidence in a way that protects a prior opinion.
- QME example: The QME attributes an error to poor records but does not reconsider the reasoning in the original report.
- Liking bias: The QME gives a favorable person less scrutiny.
- QME example: The QME accepts a friendly examinee's account despite a conflict with the early records.

PRIMACY AND RECENCY EFFECTS

The first or most recent information can receive too much weight.

- Primacy: An early description shapes how the QME interprets later evidence.
- QME example: The first cover letter describes a minor strain. The QME discounts later findings that suggest another condition.
- Recency: The latest information overshadows the earlier chronology.
- QME example: A recent flare dominates the opinion, although earlier records document months of stable function.

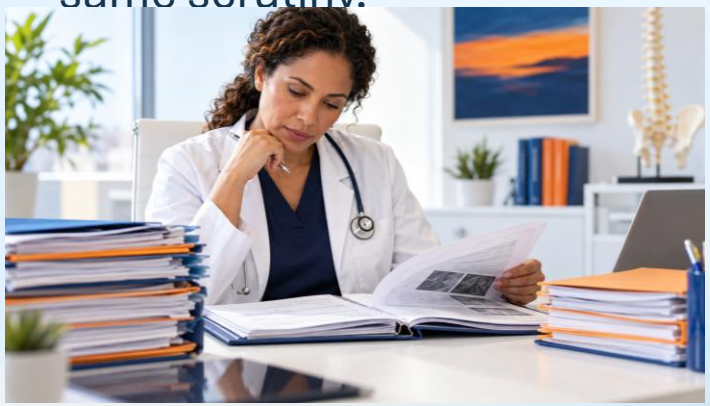
THE INTERVIEW CHECK

- Ask each examinee the same core questions about onset, work duties, prior symptoms, and daily activities.
- Clarify terms without judgment. Provide an interpreter when needed.
- Give the examinee time to correct or explain the history.
- Record the examinee’s account separately from the QME’s interpretation.



THE REVIEW OF RECORDS CHECK

- Identify the source and date of each important assertion.
- Find evidence that challenges the first impression and the proposed explanation.
- Compare the chronology with the claimed mechanism and examination findings.
- Explain important conflicts. Give supporting and contrary records the same scrutiny.



THE REPORT LANGUAGE CHECK

- “The examinee states…” identifies information from the examinee.
- “Examination showed…” identifies an observed finding.
- “In my opinion…” identifies the QME’s conclusion.
- “The January 12 record documents shoulder pain” identifies the source.
- “The examinee gave two different injury dates” describes a specific discrepancy.
- “The examinee reports that authorization delayed therapy” explains a gap in care.
- State what the examinee reported, what the QME observed, and why the QME reached the opinion.

PART 2: GENDER BIAS AND BREAST CANCER

- How gender assumptions can affect apportionment.
- How gender bias can affect ratings for industrial breast cancer.

PAGE VS. PARISOTTO (2016)

- THE ORIGIN OF THE CONCERN FOR BIAS IN THE MEDICAL LEGAL EVALUATION:
- “California’s system of examinees’ compensation perpetuates the type of overt sex discrimination that is a relic of a past era. It deprives women examinees of fair compensation on the basis of stereotypes about gender and women’s reproductive biology.”

ALLEGATIONS OF GENDER BIAS

- Specifically, the examinees compensation system unlawfully discriminates on the basis of sex in the calculation of permanent disability benefits – benefits intended to compensate injured examinees for long term physical loss and the loss of earning capacity - in two ways:
- The permanent disability benefits to which injured women examinees are entitled are reduced for no reason other than the examinee's gender. Women's permanent disability benefits are routinely reduced because women's injuries are apportioned - that is, attributed in part to the "risk factor" or "predisposing condition " of the female gender or women's reproductive biology.
- Women receive fewer permanent disability benefits than the extent of their injuries merit because harm unique to women is ignored.

THE CLASS ACTION ALLEGATIONS

- “Class Action Law Suit vs. DWC:
- California’s system of examinees’ compensation perpetuates the type of overt sex discrimination that is a relic of a past era. It deprives women examinees of fair compensation of the basis of stereotypes about gender and women’s reproductive biology.
- Specifically, the examinees compensation system unlawfully discriminates on the basis of sex in the calculation of permanent disability benefits – benefits intended to compensate injured examinees for long term physical loss and the loss of earning capacity - in two ways:
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- Women receive fewer permanent disability benefits than the extent of their injuries merit because harm unique to women is ignored.

TWO CONCERNS ABOUT GENDER BIAS

- “Specifically, the examinees compensation system unlawfully discriminates on the basis of sex in the calculation of permanent disability benefits – benefits intended to compensate injured examinees for long term physical loss and the loss of earning capacity - in two ways:
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THE CLAIMANTS' EVALUATIONS

- Claimant 1- CTS Impairment Rating apportioned 20% to non-industrial risk factors (gender)
- Claimants 2 &3 – Industrial Breast Cancer – No Impairment Rating following double mastectomy…. No Impairment rating following single mastectomy

GENDER AND CARPAL TUNNEL SYNDROME

6. **Plaintiff Leticia Gonzalez** has been a technician with the same telecommunications company since 1998. For seventeen years, Ms. Gonzalez spent 8 hours a day, five days a week, working on a computer in order to carry out her job duties. The repetitive nature of this heavy computer use began to cause her significant discomfort, and eventually the pain and numbness in her hands and shoulders had become so extreme that she was unable to sleep for more than four or five hours a night or perform many self-care activities and work-related duties. Ms. Gonzalez filed a claim for workers' compensation and began seeking medical care. Her conditions did not improve with conservative treatment, and she underwent surgery on her right hand. Although the surgery alleviated the severe pain and numbness in her right wrist, the pain in her neck, right shoulder, right arm, and left wrist has only gotten worse, and it continues to impact both her work and her sleep.

THE CARPAL TUNNEL CASE

- Apportionment to Gender in a Case of Carpal Tunnel Syndrome

7. In 2014 a Qualified Medical Examiner (QME) deemed her permanent and stationary and diagnosed her with, *inter alia*, carpal tunnel syndrome and "neuropathy"—or nerve damage. The QME report confirmed that these injuries were caused by the physical demands of her occupation and concluded that she was entitled to permanent disability benefits. However, based on one, fifteen-minute examination, the QME apportioned 20% of her disability to non-industrial factors, concluding, "***she has multiple risk factors for carpal tunnel syndrome primarily age and gender,***" and noting, "***Carpal tunnel compression neuropathy is almost ubiquitous in the female population in her age demographic.***" In other words, the QME concluded that Ms. Gonzalez should receive 20% less in disability benefits for no reason other than stereotypes about her gender and age.

CARPAL TUNNEL SYNDROME RISK

- Carpal Tunnel Syndrome
- https://www.womenshealth.gov/a-z-topics/carpal-tunnel-syndrome
- The U.S. Department of Labor reported that in 2015 the average number of missed days of work due to CTS was 28 days.
- “Women are three times more likely to have CTS than men. Although there is limited research on why this is the case, scientists have several ideas. It may be that the wrist bones are naturally smaller in most women, creating a tighter space through which the nerves and tendons must pass. Other researchers are looking at genetic links that make it more likely for women to have musculoskeletal injuries such as CTS. Women also deal with strong hormonal changes during pregnancy and menopause that make them more likely to suffer from CTS. Generally, women are at higher risk of CTS between the ages of 45 and 54. Then, the risk increases for both men and women as they age.”

RATING CARPAL TUNNEL IMPAIRMENT

- Carpal Tunnel Syndrome
- Rating Permanent Impairment

If, after an *optimal recovery time* following surgical decompression, an individual continues to complain of pain, paresthesias, and/or difficulties in performing certain activities, three possible scenarios can be present:

1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS is rated according to the sensory and/or motor deficits as described earlier.
2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed 5% of the upper extremity may be justified.
3. Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength, and nerve conduction studies: there is no objective basis for an impairment rating.



APPORTIONMENT TO GENDER

- Carpal Tunnel Syndrome – “Impermissible Apportionment to Risk Factors for Injury” – Page vs. Parisotto

THE APPORTIONMENT EXAMPLES

- 80% of carpal tunnel syndrome apportioned to nonindustrial causes including gender: ***"The most significant factor in development of carpal tunnel syndrome is simply gender. Females have considerably higher incidence, probably in the five to six times range compared to males."***
- 90% of carpal tunnel syndrome apportioned to "an accumulation of stresses ***plus the risk factor of the female gender. . . ."***
- 40% of carpal tunnel syndrome apportioned to "*preexistent non-industrial factors*" including "***female gender, age [and] post-menopausal status.***"
- 10% of carpal tunnel syndrome apportioned to pregnancy, based on a finding that ***"risk factors for carpal tunnel syndrome include female sex [and] pregnancy."***

MORE APPORTIONMENT EXAMPLES

- 40% of carpal tunnel syndrome apportioned to "***preexistent non-industrial factors***" including "***female gender, age [and] post-menopausal status.***"
- 50% of carpal tunnel syndrome apportioned to "*the fact that* ***she is a postmenopausal,*** *slightly overweight* ***woman,***" because "*the apportionable disability is based on the fact that the* ***highest incidence of carpal tunnel syndrome is in postmenopausal women.***"

AVOIDING BIAS IN APPORTIONMENT

- Apportionment Considerations in the War Against Bias
- No Apportionment based on “risk factors:”
  - Race
  - Gender
  - National Origin
  - Religious Orientation
  - Sexual Preference



INDUSTRIAL BREAST CANCER

- INDUSTRIAL BREAST CANCER

10. **Plaintiff Dorene Hansen** has worked as a police officer for 19 years. Since 1997, Officer Hansen has been a member of a K-9 unit, responsible for training and working with police dogs. Officer Hansen's job duties have included searching laboratories where chemical tests were being conducted, traffic control and investigations at major vehicle accidents and hazardous material spills, and crowd control, evacuations, and evidence collection at the scenes of car, home, and business fires—including a fire at a dry cleaning facility. For the first 3 years of her employment, she was exposed to significant second-hand smoke in the police station and patrol car.

THE FIRST BREAST CANCER CASE

11. Officer Hansen developed bleeding from her left nipple and, after undergoing a mammogram and breast biopsy, was diagnosed with stage four cancer in her left breast. Officer Hansen then underwent a double mastectomy that included the removal of the lymph nodes along her left side. Officer Hansen learned that there were certain cancer diagnoses that presumptively fell within the parameters of California's workers' compensation system and proceeded to file a claim. Officer Hansen then underwent reconstructive surgery, received chemotherapy, and began taking the hormone therapy Tamoxifen. Both the cancer and the necessary treatment she has received have significantly impacted her life. To this day, she continues to experience chemotherapy-induced numbness in her hands and feet. The hormone therapy induced early menopause and creates a heightened risk of ovarian cancer, requiring Officer Hansen to undergo

THE SECOND BREAST CANCER CASE

12. Her employer's workers' compensation insurer instructed her to see a Qualified Medical Examiner. Despite concluding that Officer Hansen's breast cancer was caused by her employment, the Qualified Medical Examiner assigned her a permanent disability rating of **zero**. Officer Hansen, who was not represented by an attorney, subsequently signed a stipulation approved by a Workers' Compensation Administrative Law Judge that ratified the 0% permanent disability rating. In short, the workers' compensation system determined that Officer Hansen was not entitled to any permanent disability compensation for the loss of both of her breasts and the attendant consequences she has endured, many of which continue to plague her to this day.

BREAST CANCER AND THE AMA GUIDES

10.9 Mammary Glands

The mammary glands make, store, and secrete milk. Absence of the mammary glands does not cause impairment of the whole person in males, but in females it will prevent nursing. In some endocrine disorders, there may be galactorrhea in females and gynecomastia in males. Gynecomastia in males may be accompanied by galactorrhea.

THE RATING DISCUSSION

10.9a Criteria for Rating Permanent Impairment Due to Mammary Gland Disorders

A female of childbearing age with absence of the breasts, an individual with galactorrhea sufficient to require the use of absorbent pads, and a male with painful gynecomastia that interferes with performance of activities of daily living each would have 0% to 5% impairment of the whole person. If there were a coexisting psychiatric impairment, the whole person impairment would be greater (see Chapter 14, Mental and Behavioral Disorders).

EFFECTS OF BREAST CANCER TREATMENT

- INDUSTRIAL BREAST CANCER – CONSIDERATIONS:
- In the context of industrial breast cancer and its treatment, women who undergo single or double mastectomy may face a variety of impairments and complications that extend beyond the direct loss of breast tissue. Despite the AMA Guides sometimes assigning low or no permanent impairment ratings for mastectomies themselves, the broader effects of the surgery and associated treatments like chemotherapy and radiation can be significant and multifaceted. Here are some potential impairments and effects:
- Lymphedema: Post-mastectomy, there is a risk of lymphedema, particularly when lymph nodes are removed. This can cause swelling in the arms and upper body, which can be painful and limit mobility.
- Pain and Sensation Changes: Chronic pain and changes in sensation, including numbness or tingling in the chest and upper arm areas, can persist after surgery.
- Reduced Range of Motion: Surgery and radiation can lead to fibrosis and scarring that stiffens tissues, reducing the range of motion in the shoulders and arms.
- Emotional and Psychological Impact: Depression, anxiety, and issues with body image are common, significantly affecting mental health and quality of life.

CLOSING REMARKS

- Recognize how bias can influence a QME’s conclusions.
- Base each opinion on the examinee’s evidence and functional limitations.
- Explain apportionment and impairment ratings with clear medical reasoning.
- Apply these principles throughout the examination and report.

