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**Presented by:**

**Perry J. Carpenter D.C., QME**

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| DECEPTION, SYMPTOM MAGNIFICATION, AND MALINGERING |
| Perry J. Carpenter D.C., Q.M.E. |
| Continuing Education Provider #1280 |

As Qualified Medical Evaluators, we encounter injured workers who attempt to tell you about their injury (ies). In interviewing the examinee, discussion quickly devolves to a description of various painful symptoms. Is it possible for us as examiners to be able to understand what and how the examinee is feeling in their physical body? Like other conundrums, the answer – predictably – is “no” and… “yes.”

* “No.” Because pain is not something that can be felt, or seen, or measured by the examiner, there is no way to determine what the examinee is describing and further, there is no way to ascertain the true presence or absence of the painful sensation that the examinee reports.
* “Yes.” Because with an understanding of some common concepts and terms, we can develop a construct of 1) the level of pain reported by the examinee and further, 2) the impact of the reported pain on the ability to perform activities of daily living and, with that information, we can proceed with our determination of issues in the Worker’s Compensation arena including 1) Permanent & Stationary status, 2) Permanent Impairment, 3) Causation/Apportionment of the Permanent Impairment, and others.

All of us have experienced pain at one point or another in our lives. All of us can agree that pain is quite worrisome. How would you define “pain?” Pain can be defined as:

Simply, pain can be thought of as an unpleasant *sensory* and *emotional* experience associated with actual tissue damage, or potential tissue damage, or described in terms of such damage. The *sensory* perception of tissue damage is picked up in the periphery. The *emotional* interpretation of the pain takes place in the mind. As Qualified Medical Evaluators, our job is to identify the *cause* of the pain. Our job is to identify the actual tissue damage responsible for the report of pain that our examinees report. With the multiplicity of behavioral, cultural, and gender confounders, this is no easy task. This article explores issues related to pain, symptom magnification, deception, and malingering and provides the QME with a practical physical examination toolkit that will provide to the examiner the information necessary to translate the subjective complaints reported by the examinee into a language that funnels down to conclusions as they apply in the specialized setting of Worker’s Compensation.

**2001 PHYSICIAN’S GUIDE**

Although in limited use now with the adoption of the AMA Guides 5th Edition, the 1997 Permanent Disability Rating Schedule (PDRS) provides permanent disability for chronic, permanent pain. These “Subjective Factors of Disability” represent the QME examiner’s professional *interpretation* and *translation* of the examinee’s reports of pain into a language that can be used to determine benefits appropriate for the injured worker. Because the examinee’s pain cannot be seen or felt by the examiner, the defined concepts of the “Subjective Factors of Disability” give the examiner one method to determine the severity of any pain by converting all of the examinees many verbal descriptions into a quantifiable construct. Although the 1997 PDRS is being used less and less as time advances and most injuries fall under the AMA Guides 5th Edition, the descriptions of pain used in determining “Subjective Factors of Disability” are illustrative and still valid in giving the QME examiner an indication of the impact that the pain has on the examinee and, allows the examiner to extrapolate those pain limitations to the more recently required analysis of “activities of daily living” as required by the AMA Guides. The 2001 Physician’s Guide defines 4 levels of pain – each with a specific level of impact on the ability to perform activity:

QUANTIFYING PAIN

**Minimal Pain** – Never tell an injured worker or other person that the pain that they are experiencing is “minimal.” That is certain to get you beat up because there is no way you are going to tell someone that the terrible, excruciating, crushing, searing, blinding pain they are describing to you is “minimal.” Because pain is an “unpleasant *sensory* and *emotional* experience”, the mind and emotions magnify the pain and, when describing the pain to others, in order to get across to them the suffering and distress, in order to help others to feel what they are feeling, all descriptions of pain default to “terrible”, “excruciating”, and “severe.” And you can probably relate to this. Certainly any man who has suffered a back strain or a flu will attest to these descriptions. You lay there on the couch, moaning for all to hear, hoping - just hoping - that someone will bring you a bowl of chicken soup and a blanket. Oh yes, when it happens to you, pain is “terrible.” Right men? Right ladies? However, no matter how “terrible” pain may be described, most pain is actually “minimal” pain because – consistent with the definition found in the 2001 Physician’s Guide - that pain does not cause handicap in the performance of the activity that causes the pain. A couple of examples will illustrate:

1. A basketball player comes off the court at halftime and tells the team trainer “My knees are killing me.” In the second half of the game this same player scores 20 points and gets 10 rebounds. What do we know in this scenario? Do we know if the player actually has pain in the knees? Answer: No – we do not know. We cannot see his pain. We cannot feel his pain. We don’t know if he has pain in his knees or not. All we can do as an observer in this case is to observe the player and look for manifestations of the impact of the pain on his ability to perform – in this case not “activities of daily living” but rather, his ability to perform on the basketball court. In other words, we observe for outward, objective, visible impact of the reported pain on his ability to 1) run up and down the court, 2) to jump, 3) to pivot, twist, and turn, and 4) to be a basketball player in full, unrestricted form. And in this example, we do not see any outward, objective, visible impact of the pain on the ability to play basketball. The player runs up and down the court at full speed. He stops. He starts. He jumps. He fights for rebounds. He shoots. He scores. I think you get the point. This is minimal pain because the pain that he reports in his knees – now matter how bad it may seem to him to be (“killing me”) – causes no handicap in the performance of the activity (playing basketball) that is reported to cause pain.
2. An examinee tells you about pain in his left shoulder joint. The examinee tells you “I don’t know what is wrong with my shoulder but when I raise my arm like this (demonstrates by raising the arm overhead), I get a sharp pain in my shoulder. It feels like an ice pick in the center of this joint.” What do we know in this scenario? Do we know if there is pain in the shoulder? Answer: No – we do not know. We cannot see the pain. We cannot feel the pain. We don’t know if there is pain in the shoulder or not. What we do as astute observers is to look for manifestations of the impact of the reported pain on the ability to perform the activity that causes pain. In this case the activity is reaching overhead. And we don’t see any. We don’t see any grimace. We don’t see any painful arc. We don’t hear any joint crepitus. We do not observe apprehension. The arm goes completely up and overhead to 180 degrees of shoulder flexion or abduction. This is “minimal pain” because the pain that he reports in the shoulder – no matter how bad it may seem to him to be - causes no handicap in the performance of the activity (raising the arm overhead) that is reported to cause the pain.

**Slight Pain** – Occasionally you will see examples of slight pain where the pain causes some handicap in the performance of the activity that causes the pain. This means that the pain disadvantages the activity that causes the pain. What qualifies as “some handicap?” This is open to interpretation but the disadvantage should be accompanied by an outward, visible, objective alteration in the performance of the activity. Examples of slight pain could include:

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| Minimal Pain = “no handicap  Slight Pain = “some handicap”  Moderate Pain = “marked handicap”  Severe Pain = “precludes activity” |

1. A basketball player comes off the court and halftime and tells the team trainer “My knees are killing me.” This is not new news to the trainer because, throughout the game, the player was observed to be able to run at only ¾ speed up and down the court. He was observed to have a shortened stride length when running. On several occasions, he was observed to hang out at mid court rather than running deep into either the offensive or defensive zones. In the training room at halftime, the trainer observed slight retropatellar effusion bilaterally. The right knee was painful in full passive extension and for comfort, the player rested with the knee in 15 degrees of flexion. What do we know in this scenario? We know that the pain is more than “minimal” because we see outward, objective indications of the impact that the pain has on the ability to perform. We see objective indications of *handicap* in the performance of playing basketball. Can he still play? Yes, he can still play. He can play as long as he and the coach agree that his ability to perform is a benefit to the team and not a threat to his health. The key criteria in this example are the presence of 1) objective, outward sign of handicap in the performance of the activity and 2) objective Physical Examination findings.
2. An examinee tells you about pain in his left shoulder joint. The examinee tells you “I don’t know what is wrong with my shoulder but when I raise my arm like this (demonstrates by raising the arm overhead), I get a sharp pain in my shoulder. It feels like an ice pick in the center of this joint.” On observing the examinee to bring his arm overhead, we note a painful arc between 80-120 degrees of abduction. At 80 degrees, the examinee quickly brings the elbow in close to the body and, with the arm hugging close to the body, slowly, slowly raises the arm overhead. Nearing full abduction, we hear a sharp POP from the glenohumeral joint. The examinee lowers the arm the same way – by bringing the arm down close to the body and slowly returning the arm to the side. On Physical Examination, we note a positive sulcus sign and a positive apprehension maneuver. What do we know in this scenario? We know that the pain is more than minimal because we see outward, objective indications of the impact that the pain has on the ability to raise the arm overhead. We see objective indications of *handicap* in the performance of shoulder abduction. Can he still raise the arm overhead? Yes, he can raise the arm overhead. However, the maneuver is modified, changed, altered, limited, or *handicapped* in some way that is objective, visible, verifiable, and repeatable. Key criteria in this example are the presence of 1) objective, outward sign of handicap in the performance of the activity and 2) objective Physical Examination findings.

**Moderate Pain** – Many examinees in the Worker’s Compensation system, and people in general, will report that their pain is “moderate.” They report “moderate” pain because they are not aware of the definition of this term as it is used in Worker’s Compensation. This is normal. “Moderate” is a description that can be safely used by the lay person because it does not appear to be overly exaggerated. It is not “severe.” It is not “excruciating.” It is not “awful.” It is credible because it leaves room for situations where other people could have worse pain. However, true “moderate” pain is rare. By definition, “moderate” pain is pain that causes a *marked handicap* in the performance of the activity that causes the pain. What would qualify as “marked handicap?” A “marked handicap” would be obvious and plain for all to see. To continue the above examples:

1. A basketball player comes off the court and tells the trainer “My knees are killing me.” This is not new news to the trainer because earlier in the game, the player was involved in a collision that caused him to come down to the floor with his feet out from under him – landing directly on the patellae. He lay on the ground writhing in pain as the team took a 2 minute time out. After being helped to his feet by his teammate, he started to slowly walk around, with a noticeable limp on the right. After making 1 of 2 free throws, he was noted to not be able to run. Another time out was taken and the player was removed from the court – walking off with the help of 2 team trainers. What do we know in this scenario? We know that pain – with its inhibitory effect on alpha motor neurons – has taken away this player’s strength in the legs or for any activity that requires the application of strength through the knees. This pain causes a *marked handicap* in the activity that causes the pain. In this scenario, the “activity” is not the larger activity of being able to play basketball. No. The activity is now much more limited and much more handicapped. Now, the activity reduces to the ability to operate the legs. The ability to walk. The ability to stand. The ability to flex and extend the knee. The ability to apply pressure to the foot. This is a much more limited scope of activity than the multiple complex and compound movements involved in playing high level basketball. Now we are talking simply about the ability to bear weight, and to walk, and to stand. This is “moderate” pain. Can the player bear weight? Can he walk? Yes – but barely. In this example, neurologic inhibition due to nociception causes a “marked handicap” in the activity and this is plain for all to see. And Objective Physical Examination Findings are readily evident.

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1. An examinee tells you about his left shoulder pain. He tells you that “I can’t raise my arm above my shoulder. I can move it down by my waist but not above my shoulder. On observation, you note that as the examinee raises the arm in abduction, at 60 degrees of abduction his face winces terribly and the arm drops down 15 degrees to about 45 degrees of abduction. You ask the examinee “What happened?” He replies, “I don’t know, I just got a sharp pain and I can’t lift it.” You ask him “I see – but, even though there is pain, CAN you lift it?” He tries again and again is the same result – he gets a sharp pain at 60 degrees of abduction. You believe that he genuinely cannot lift the arm above 60 degrees of abduction. In this example, pain inhibition due to nociception causes a *marked handicap* in the activity and this is plain to see. There still is some movement at the shoulder – for example, shoulder extension is preserved. Shoulder internal rotation is preserved. But, at least for the movement of shoulder abduction, we conclude that pain causes a *marked handicap* in the ability to perform shoulder abduction. Handicap is not “complete” because there is still approximately 60 degrees of abduction left – there is not total loss of abduction, but the majority of abduction is not possible. And Objective Physical Examination Findings are readily evident.

**Severe Pain** - We rarely see examinees in “severe” pain because severe pain is more seen in the acute setting rather than in the chronic setting such as we see injured workers for their QME examinations. People in severe pain find themselves in the Emergency Departments of hospitals on gurneys. We don’t see examinees walking in to their QME appointments in severe pain. How would “severe” pain appear in the example of the basketball player? Well, according to the definition, “severe” pain is pain that “precludes the activity causing the pain.” What is the activity (ies) of the knees? The activities of the knee are to bend, to bear weight, to walk, to squat. In the presence of severe pain, the player would be required to use crutches or a wheelchair due to preclusion from weight bearing. What about the example of the shoulder pain? Severe pain would require that the arm hang limply from the side, perhaps in a sling, with no motion. And, in both examples, the Physical Examination would be obvious for Objective findings supportive of a conclusion of “severe” pain.

**THE QME INTERVIEW**

So, you can expect examinees to mis-describe their symptoms because, of course, injured workers are not versed in the technical definitions that we use in the Workers Compensation system. Important considerations for the doctor in assigning the correct level of pain revolve around the impact of the pain on the ability to complete the activity. And activity is assessed both in the interview of the examinee, and during the Physical Examination. During the interview, activity is observed casually by the doctor without attention drawn to any contradictions to the stated level of pain and the casually observed level of activity of the examinee. During the Physical Examination, activity is observed more formally. Examples of possible casually observed mismatches of stated pain levels and true activity capacity include:

* The examinee reports right shoulder pain and indicates on a Pain Drawing Diagram that the level of pain is an “8” on a “10” point pain scale however, during the interview process, the examinee is noted to gesture freely, and at times forcibly, with the right upper extremity – even raising the right arm quickly over head to emphasize spoken points. You note that, whatever pain may be present in the shoulder, that pain does not interfere with the ability to raise the arm quickly and forcibly. This is “minimal” pain and does not qualify as an “8.”
* The examinee reports lower back pain and states that, anytime he bends over, he gets a sharp pain in the lower back. During the interview, you note that the examinee sits comfortably for over 30 minutes sitting upright in his chair with the knees and hips flexed to 90 degrees. He rises quickly from the chair without assistance from the hands. During the Physical Examination, on lumbar spine flexion testing, the examinee bends over, touches his toes with his fingertips and states that there is a sharp pain in the lower back when he does this. What do we know? We know a lot because even though we do not know 1) what the pain feels like, 2) where the pain is coming from, 3) what type of pain there is, or 4) how they feel about the pain, we do know that, whatever pain is actually present, that pain does not interfere with the ability to perform lumbar flexion. This is “minimal” pain.

ACTIVITES OF DAILY LIVING ASSESSMENTS

These examples, and many more that probably come to your mind from your own experience illustrate the QME evaluator’s role in translating the pain language expressed by the examinee into language that can be used in the Workers Compensation systems. While the language of the 1997 Permanent Disability Rating System is being used less and less as dates of injury advance and the AMA Guides become the required method of determining Permanent Impairment, it is my opinion that the pain definitions of “minimal”, “slight”, “moderate”, and “severe” have application to the AMA Guides systems particularly as applies to the Activities of Daily Living Assessment. Because the AMA Guides rely heavily on an assessment of the impact of the injury/condition on the ability to perform general activities of daily living, the Activities of Daily Living Assessment should be a formal part of the face to face evaluation of the injured worker.

The AMA Guides 5th Edition describes common “activities of daily living” (page 4) as follows:

The Activities of Daily Living Assessment requires us a Qualified Medical Evaluators to translate the reported impact of the injury, condition, or pain (as described by the examinee) on the ability to complete activities of daily living, into language that can be used to determine the presence or absence of Permanent Impairment as a result of said injury, condition, or pain. One way of doing this is to take the examinee on a journey through the activities of daily living categories while you as the Evaluator assign a rating level of “minimal”, “slight”, “moderate”, or “severe” to the description given by the examinee. An example of this Assessment as relates to “Self Care and Personal Hygiene” might be as follows:

* Self Care and Personal Hygiene:
  + Doctor: “Mr. Smith, I am going to ask you some questions about how your lower back and right leg pain affect your ability to do various activities. These activities are termed “Activities of Daily Living” and these are activities that you would do on a daily basis as you go about your day. The first of these categories is “Self Care and Personal Hygiene.” Do you have any problems with being able to manage your own self care and personal hygiene?”
  + Examinee: “Oh yes, I have trouble doing most everything. With my pain, I can barely function.”
  + Doctor: “OK - I am going to give you a list of various “self care and personal hygiene” activities and I want you to tell me if, or how, your lower back and right leg pain interferes with your ability to care for yourself.”
    - Urinating:
      * Doctor: “Mr. Smith, do you have any problem using the bathroom for urination?”
      * Examinee: “No – I can urinate fine.”
    - Defecating:
      * Doctor: “Mr. Smith, do you have any problem using the bathroom for defecating?”
      * Examinee: “No – I can defecate fine. Sometimes though, because of my pain, I have trouble wiping myself because of the twisting.”
      * Doctor: “I understand. DO you wipe yourself or do you have to get help with this?”
      * Examinee: “Oh yeah, I wipe myself.”
    - Brushing Teeth, combing hair, bathing:
      * Doctor: “Mr. Smith, do you have any problem with brushing your teeth, combing your hair, or bathing?”

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* Examinee: “Yes – it hurts my lower back and right leg to bend over the sink to brush my teeth. And, when I shower, it hurts to bend over to wash my feet.”
* Doctor: “I understand. CAN you brush your teeth by yourself?
* Examinee: “Oh yeah – if my back is hurting I just do it standing up instead of bending over.”
* Doctor: “CAN you wash your feet?”
* Examinee: “Oh yeah – I just put one foot up on the ledge and bend over to do it that way.”
* Doctor: “Got it.”
* Dressing Oneself:
* Doctor: “Mr. Smith, do you have any problem dressing yourself?”
* Examinee: “Yes. I have a lot of lower back and right leg pain with putting on my pants, and my shoes and socks.”
  + - Doctor: “Did you dress yourself in coming here to this evaluation?
    - Examinee: “Yes.”
    - Eating:
      * Doctor: “Mr. Smith, because of pain in your lower back and right leg, do you have any problem with eating?”
      * Examinee: “Well kind of. I have pain with sitting down to eat a meal.”
      * Doctor: “Are you missing meals? Have you lost weight?”
      * Examinee: “No – I guess I’m not missing any meals.”
      * Doctor: “Uh-huh.”
    - Other:
      * Doctor: “Mr. Smith, can you think of any other examples of how your lower back and right leg pain interferes with your ability to handle your own “self care and personal hygiene?”
      * Examinee: “No – that’s about it.”

This would be an example of “minimal” pain because the pain in the lower back and right leg – however constant, severe, and impairing it is felt to be by the examinee – does not really interfere with the ability to perform the activities (in this case “self care” activities). This is a valuable insight and I repeat this procedure with each of the activities of daily living categories right down through the list. This procedure helps immeasurably to assist in translating the examinee’s descriptions of pain into something that we – as the Qualified Medical Evaluators – can work with. I recommend that this Assessment of Activities of Daily Living be done with each examinee and I recommend that it be done in the face-to-face interview rather than by means of a pre-completed form that is simply filled out by the examinee in either a check box or fill-in-the- blank format. You are after evidence of how the reported symptoms (in this example, the lower back and right leg pain) actually impact (impair) the activity. The AMA Guides 5th Edition defines “impairment” as “a loss, loss of use, or derangement of anybody part, organ system, or organ function (page 2).” And…. “an impairment may lead to functional limitations or the inability to perform activities of daily living.” In the example above, the lower back and right leg pain do not really – or only minimally - impair the daily living activities of “self care and personal hygiene.”

**SYMPTOM MAGNIFICATION AND MALINGERING**

Terms common in the Workers Compensation arena that deal with examinee presentation and perceptions of pain include “Malingering”, “Symptom Magnification”, “Symptom Amplification”, “Deception”, and “Somatization.” The balance of this discussion concerns malingering, symptom magnification, and deception.

* Malingering:
  + Merriam-Webster Dictionary: “to pretend or exaggerate incapacity or [illness](http://www.merriam-webster.com/dictionary/malinger##) (as to avoid duty or work).”
  + Diagnostic and Statistical Manual of Mental Disorders IV (hereinafter referred to as the DSM-IV): “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.”
  + In the Workers Compensation setting, this amounts to deliberate and fraudulent feigning of symptoms. Important in understanding malingering is the fact that claims of symptoms, impairment, and disability are willfully, intentionally, and deliberately overstated.
* Deception (Merriam-Webster): “to cause to accept as true or valid what is false or invalid, to give a false impression.” This may include statements or physical acts the purpose of which are to propagate beliefs that are not true, or are not the whole truth. This may also include omission or withholding of information.
* Symptom Magnification (Merriam-Webster): “the patient exaggerating or magnifying their actual complaints in order to "sell" the doctor on the truth of their claims.”

MALINGERING

The Diagnostic and Statistical Manual of Mental Disorders IV (hereinafter referred to as “DSM-IV”) describes 4 criteria for malingering. Those include:

According to the DSM-IV, the presence of 2 of the 4 criteria suggests probable malingering. While the DSM-IV has been criticized, the 4 criteria are useful guideposts that the evaluator can consider when assembling the final conclusions on Permanent Impairment. Examples of suggested malingering based on the above criteria could include:

* Medical-Legal Context: Interestingly, because of the medical-legal context of the QME examination, ALL examinees can be considered to meet at least Criteria 1. ALL examinees find themselves – either willingly or unwillingly – in the medical legal context of the Workers Compensation system. Therefore, you can expect – in advance - that examinees may overstate 1) their symptoms and 2) the impact of those symptoms on their ability to complete activities of daily living. Just the very fact that the examinee showed up to the appointment indicates that they want to convince you as the Evaluator of something. The question becomes – what is that “something?” In my experience with thousands of injured workers, very few come to the appointment to convince me that they are 100% better and are completely recovered from their injuries. Very few come to the appointment and state “You know, because of the Physical Therapy that I had I am in even better and stronger shape than I was before the injury. I am so good now that I am the high scorer on my ice hockey team!” I have had a few of those examples but, again, it is few.
* Marked Discrepancy: The opposite is more often the case as injured workers come to the appointment to report their problems and, as the Evaluator, it is important to put the reported problems into the overall context of the case. Examinees report problems with their injury/condition. Problems with their employer. Problems with their family. Problems with their finances. Problems. Problems. Problems. Problems are a normal and natural part of life and in this setting, be alert for problems that are out of proportion to the mechanism of injury and far outside of what would be considered a normal healing response in an otherwise healthy person. An example from my recent case files that raised my suspicion for “marked discrepancy” involved a 52 year old male (Mr. Jones) who was on the second step of a 3 step stool. Mr. Jones was arranging paper cups and paper plates on a shelf in kitchen cabinets when he lost his balance and stepped down to the ground – a height of 2 feet below the second step of the step stool. He landed awkwardly on to his left leg. He did not fall. He did not think much of this and he continued working. The next day he woke up with pain in the lower back and he reported this to his Supervisor. Medical treatment was arranged and he was diagnosed with “lumbar sprain/strain.” He was given the remainder of the day off to rest his back. Pain did not resolve and the Primary Treating Physician provided return to work recommendations of “no lifting over 10 lbs., no bending below waist level, no standing greater than 20 minutes.” These were restrictions that the employer was not able to accommodate and so Mr. Jones stayed at home on Total Temporary Disability. Diagnostic Studies including lumbar spine x-rays, lumbar spine MRI, and lumbar spine and lower extremity electrodiagnostic studies were significant only for age related degenerative changes of the last 2 segments of the lumbar spine. 6 sessions of Physical Therapy did not help. Injection to the right sacroiliac joint did not help. 3 series of selective nerve root blocks did not help. 6 sessions of Chiropractic did not help. The combined suggestions and recommendations of 1) the Primary Treating Physician, 2) a Physical Medicine and Rehabilitation Specialist, 3) an Orthopedic Surgeon, 4) a Physical Therapist, and 5) a Chiropractor did not help to bring about a resolution of Mr. Jones’ lower back pain symptoms. When I evaluated Mr. Jones for a Qualified Medical Evaluation for the second time, he reported continued worsening of his back pain despite 15 months of Total Temporary Disability. He presented to the evaluation without cane, brace, or other assistive device. Physical Examination demonstrated normal lumbar spine and lower extremity neurologic function. Lumbar spine range of motion was limited in all ranges due to report of lower back pain. This is an example of a disability that is out of proportion to 1) the mechanism of injury and 2) the Objective Findings on Physical Examination. Because Criteria 1 (above) is already met due to the medical legal context of the evaluation, the presence of a “marked discrepancy” between the claimed disability and the Objective Findings establishes 2 of the DSM-IV criteria and could lead the Evaluator to the possibility that malingering and/or symptom magnification could be present.

*Malingering – DSM-IV*

* *Medical Legal Context of Presentation*
* *Marked Discrepancy*
* *Lack of Cooperation*
* *Antisocial Personality*
* Lack of Cooperation with testing or treatment: An examinee who is malingering may not cooperate with medical providers. The DSM-IV describes “lack of cooperation” as occurring both 1) with the Diagnostic Evaluation, and 2) with the prescribed treatment program. The “Diagnostic Evaluation” could include 1) evaluations and testing with various Specialists and outside facilities and 2) the QME evaluation. Lack of cooperation is an effort to avoid or to confound procedures that would reveal a lack of true objective findings. The examinee may also not cooperate with the prescribed treatment program. Examples of lack of cooperation that may indicate malingering may include:
  + Diagnostic Evaluation:
    - The examinee states that they are unable to complete MRI studies because they are too apprehensive and too claustrophobic to enter the MRI tube.
    - X-ray or MRI studies are significant for motion artifact even though the examinee was instructed to hold still.
    - The examinee becomes “unavailable” for appointment days, dates, and times, despite being on Total Temporary Disability.
    - The examinee comes to the QME appointment late – causing the appointment to have to be rescheduled for a later date.
    - The examinee comes to the QME appointment without completing required paperwork despite being reminded prior to the appointment to complete all paperwork.
    - During the examination, the examinee refuses to allow manipulation of the legs (as in straight leg raising or in passive hip flexion) despite being observed to walk normally and to sit comfortably.
  + Treatment Program:
    - The examinee fails to take the prescribed medication for a variety of stated reasons – such as stated side effects to the medications. Frequently, medications are changed but still the examinee finds the medications intolerable.
    - The examinee refuses invasive procedures – such as epidural steroid injections or surgical procedures despite claimed inability to work and marked impact of the reported condition on activities of daily living. The examinee may state that “they know a friend” who had a similar procedure/surgery/treatment who “ended up worse” as a result of the procedure.
    - The examinee quits Physical Therapy after 2 sessions stating that the Therapy “made me worse.” The examinee may report new, additional symptoms as a result of the Physical Therapy.
    - The examinee quits Chiropractic treatment after 2 sessions stating that the Therapy “made me worse.” The examinee may report new, additional symptoms as a result of the Chiropractic treatment.
    - The examinee quits Acupuncture treatment after a few sessions – reporting “no help” or ‘worsening” as a result of the Acupuncture.
* Antisocial Personality Disorder: A determination of the presence or absence of “antisocial personality disorder” is outside the scope of most evaluators however, awareness of some of the characteristics of the antisocial personality can sharpen the evaluator’s thinking to the possibility of malingering. According to the DSM-IV, the antisocial personality is characterized by “a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood.” Antisocial personality disorder can be suggested 1) in the medical records, 2) in the employment records, and 3) in the Physical Examination. Examples include:
  + Medical/Administrative Records:
    - Truancy – late for work/missing work/late for medical appointments/ “no show” medical appointments
    - Lying and/or stealing
    - Substance abuse – either prescription or recreational
    - History of depression – possibly including suicide attempt
    - History of arrest
    - Use of aliases (other names)
  + Physical Examination:
    - Late or “no show” for QME evaluation
    - The examinee may be very engaging, charming, slick, and verbally facile. This describes the “superficial charm” of the anti-social personality disorder.

According to the DSM-IV, 2 of the above 4 criteria suggest malingering and/or symptom magnification. ALL examinees present with Criteria 1 because ALL examinees present with a “medical legal context” by virtue of their involvement in Workers Compensation. The exception to this would be the examinee who presents to the evaluation stating that they are fully recovered from their injury and they are simply at the examination because it is their understanding that the examination is part of the conclusory process of the claim. I have had these cases but they are few. Heightened concerns for malingering are those examinees represented by an Attorney. Thus, most if not ALL examinees fit Criteria 1 for the possibility of malingering. The History and Physical Examination will reveal the presence or absence of one or more of the remaining 3 criteria.

**PHYSICAL EXAMINATION FINDINGS OF SYMPTOM MAGNIFICATION AND MALINGERING**

SYMPTOMS AND ACTIVITIES OF DAILY LIVING QUESTIONNAIRES

As stated above, there are no hard and fast Objective measures to quantify an examinees’ report of pain. It would be great if there was such a test but there is not and so we rely on other measures to assess the consistency of an examinee’s complaints of pain and impairment For example, we ask examinees themselves to quantify their pain and the impact of their pain on the ability to perform activities through the use of Questionnaires and outcome assessment measures. These Questionnaires need to be thoroughly reviewed because their completion relies completely on the examinee’s subjectivity. A listing of Questionnaires used commonly in the Workers Compensation setting includes:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pain Drawing Diagram | Katz Hand Diagram | West Haven Yale Multidimensional Pain Inventory | Neck Disability Index | Headache Disability Index |
| Dizziness Handicap Inventory | Revised Oswestry Low Back Questionnaire | Epworth Sleepiness Scale | Disabilities of the Arm, Shoulder, and Hand Questionnaire (DASH) | Shoulder Pain and Disability Index (SPADI) |
| \*\*Beck Depression Inventory | SF-36 | Zung Self Rating Depression Questionnaire | Roland Morris Low Back Pain and Disability Questionnaire | Profile of Mood States |
| Pain Disability Index | \*\*Hamilton Rating Scale for Anxiety | \*\*Hamilton Self Rating Scale for Depression  \*\*McGill Pain Questionnaire | \*\*Beck Anxiety Scale | \*\*Pain Related Impairment Questionnaire |
| \*\*Zung Self Rating Depression Scale | \*\* Refers to Questionnaires described in the AMA Guides – pages 578-579 |  |  |  |

(All of these Questionnaires are available for download in .pdf format at www.EZQMECE.com).

However, these Questionnaires rely on the self report of the examinee and as such, are subject to the perceptions of the examinee. I find only limited use of Symptoms Questionnaires because of so many contradictory responses on Questionnaires with 1) what is stated in the medical records or 2) what is observed in the Physical Examination. For example, common is for examinees to under report their ability to sit on the Revised Oswestry Low Back Pain Questionnaire (for example) which conflicts with their observed ability to sit during the Interview and Physical Examination. Further, limited use of the Symptoms Questionnaires comes from an absolute lack of ability to corroborate the examinee’s stated limitations with the actual limitations. For example, who among us has the ability to go into the examinee’s bedroom at night to observe their stated difficulty with sleeping, or to document their stated inability to perform in sexual relations? This makes these Questionnaires of limited value other than to highlight possible inconsistencies between subjective reports and observed findings.

PAIN BEHAVIORS

Aside from Symptoms Questionnaires, examinees can give pain indications through non-verbal Pain Behaviors. The AMA Guides describe Pain Behaviors (page 580) including:

* Facial grimacing
* Holding or supporting affect body part or area
* Limping or distorted gait
* Frequent shifting of posture or position
* Extremely slow movements
* Sitting with a rigid posture
* Moving in a guarded or protective fashion
* Moaning
* Using a cane, cervical collar, or other device
* Stooping while walking

Pain Behaviors are also of limited value because these can also be manipulated by the examinee’s motive. I discuss distorted gait and use of assistive devices in another article entitled “Gait Disturbance and Assistive Devices” – also available from www.EZCONTINUINGEDUCATION.ORG. In this article, I discuss how to identify gait disturbances and also how to identify the proper use of a cane or assistive device to determine its true use and true need in the performance of activities of daily living. More reliable than Pain Behaviors to me as a Qualified Medical Evaluator are “Objective” evaluations of the examinee’s physical capacity and this is evaluated in the Physical Examination. In the History portion of the Qualified Medical Evaluation, examinee’s can deceive by overstating and magnifying their symptoms. In the Physical Examination portion of the Qualified Medical Evaluation, examinee’s can deceive by understating their ability to complete examination maneuvers. Any inconsistency between the examinee’s stated (or understated) ability and the observed ability (by the Evaluator) could suggest malingering.

EXAMINATION INCONSISTENCIES

Still talked about in the literature regarding malingering are the now classic “Waddell’s Signs” described by Gordon Waddell M.D. in his 1980 article “Non-Organic Physical Signs in Lower Back Pain.” Waddell’s Signs have come under scrutiny and it is now generally believed that Waddell’s Signs are not able to reliably discriminate organic causes of back pain from “non-organic” (pain in the absence of a structural or physiological cause for the pain) however, the presence of Waddell’s Signs on Physical Examination are relevant in the prediction of poor treatment outcomes. And, by the time the examinee gets to the Qualified Medical Evaluation, poor treatment outcomes have often been established. Thus, Waddell’s Signs are still valuable and illustrative and, taken together with other Findings on Physical Examination, give an evaluator an indication of the examinee’s true condition and true level of Permanent Impairment. You may see references in medical records of the examinee have “2 positive Waddell’s Signs” or “3 positive Waddell’s signs.” This indicates that the examiner actually considered the possibility of symptom magnification or malingering and attempted to test for that possibility. In such a case, because of the seriousness of such a finding, you will want to repeat that assessment to determine if your findings are similar to those of the prior evaluator. Waddell’s Signs are reviewed here.

Waddell described 8 signs (findings) in 5 categories of tests. A suspicion of “psychologic contribution” to the reported symptom picture was suspected with a finding of 3 or more of the Waddell’s signs.

* Tenderness assessment – with “tenderness”, there is a finding of report of tenderness to light touch of the superficial skin. An example of a finding of “tenderness” would be an examinee with a reported disc herniation at L5/S1who reports tenderness to light palpation or light probing of the lumbar paraspinal muscles. As with all findings, the report of the examinee must be put into the context of the amount of force applied by the examiner. A true finding of significant tenderness would be accompanied by a jump sign. Another example of suspicious tenderness would be a report of diffuse (non-localized) tenderness in a non-anatomic distribution as in the case of an examinee who reports lateral thigh and knee pain to light palpation of the lumbar spine.
* Simulation tests – these are tests that would appear to be testing for a true medical finding but, because they do not actually produce the movement or stress that they appear to, a positive finding would suggest symptom magnification. For example, in the case of a lower back injury, an examinee may report pain with twisting, and/or pain with lifting. Waddell described the “axial loading” and “trunk rotation” maneuvers to try to distinguish true physical findings from possible malingering:
  + With axial loading, the examiner stands behind the examinee. The examiner places his hands on the top of the examinee’s skull and applies pressure down the axis of the spine. As an examiner performing this maneuver, make sure to apply pressure gradually and do not injure the cervical spine. As an alternative, some examiners ask the examinee to place his own hands on his skull and to apply the downward pressure himself. I like to do this myself because I can gauge the amount of pressure that is applied. A positive finding on this maneuver would be an examinee that reports lower back pain with this maneuver. This is considered a non-physiologic finding because this maneuver does not actually apply significant pressure to the lumbar spine and should not aggravate back pain.
  + With truncal rotation, the examiner sits (on the examining stool) to either the front or the back of the examinee. I like to sit in the front of the examinee so that I can observe facial expression. The examiner grasps the examinee’s hands – which are hanging to the sides – and applies downward pressure to the hands. Simultaneously, the examiner rotates the shoulders and torso by directing motion at the examinee’s arms. This maneuver appears (simulates) a twisting motion but in actuality, produces rotation only at the hip sockets by moving the torso and pelvis together *en bloc* (all together). There is no motion at the lumbar spine with this maneuver but examinees do not know this. A report of lower back pain would be a suspicious finding for symptom magnification or malingering.
* Distraction Tests – these tests are based on reported positive physical examination findings (such as reported lower back and radiating left leg pain on straight leg raise testing) that are followed up later in the examination while the examinee may be distracted (such as a seated straight leg raise maneuver performed by the examinee under the guise of checking Babinski reflexes on the foot or performing sensory examination on the foot). Because the overt Physical Examination maneuver (the straight leg raise test) and the distracted Physical Examination maneuver (the sitting straight leg raise) produce the same anatomic position and stress, they should produce the same finding. Thus, an examinee that reports lower back and radiating left leg pain on straight leg raise would be expected to report the same pain with a sitting straight leg raise maneuver. Or, the examinee would be expected to be unable to straighten the knee on the sitting leg raise. Or, the examinee would be expected to lean back quickly – reducing the angle of hip flexion – as the knee comes out into full extension. There should be consistency between the overt test and the distracted test and inconsistencies would cause the examiner to be alert for symptom magnification or malingering.
* Regional disturbances – these are findings – generally neurologic findings – that deviate from known normal neuroanatomy. An example would be an examinee that reports complaints of entire leg weakness (multiple nerve roots and multiple peripheral nerves) or pain in the entire front of the leg with no pain in the back of the leg. Another example would be a report of entire foot numbness (stocking anesthesia) and entire hand (glove anesthesia) numbness. As the foot and hand are served by multiple spinal nerve roots, a finding of stocking or glove anesthesia would be a concern that should be supported by other Physical Examination findings.
* Overreactions – these are subjective findings of the examinee’s reaction to various test maneuvers and signs of overreaction could include verbal reports, facial expressions, and bodily reactions that are out of proportion to the stress of the test or maneuver. Overreactions need to be taken slightly with a grain of salt because reactions to pain are highly personal and are influenced by a variety of factors – including cultural background. Nonetheless, reactions to pain should be somewhat proportional to the stress or demand placed on the anatomic structure and reports of pain or impairment grossly out of proportion to that expected could be a sign of symptom magnification.

Just as there are no specific tests that can be used to quantify an examinee’s level of pain, there is no one test that can definitively identify symptom magnification or malingering and Waddell’s maneuvers are no exception. A positive finding on any single Waddell category does not automatically identify the examinee as a malingerer. What is important is that the Waddell’s signs indicate a pattern of behavior that may be consistent with malingering or symptom magnification and any pattern established with these Waddell maneuvers must be checked and examined for its own consistency with the medical history and other observations of the examinee. Again, no one maneuver indicates anything. It is a pattern that we are looking for. A pattern of symptom magnification may be supported with positive findings on the following Physical Examination maneuvers:

* Distraction:
  + An examinee claims to have inability to move the neck on direct testing however, is observed to rotate and bend the neck in the completion of paperwork or in following the examiner’s movements around the room.
  + An examinee claims to have inability to bend at the spine on direct testing however, is observed to neatly remove their shoes and socks for testing on the lower extremities.
  + An examinee claims to have inability to bend at the waist on direct testing due to report of lower back pain however, is observed to sit comfortably with the hip flexed 90 degrees.
  + An examinee reports lower back and radiating right leg pain with straight leg raise testing however, is observed to bend over and touch the shins, feet, or toes without a reflexive bend to the knee – to relieve the supposed sciatic nerve tension. This is known as a negative Neri’s bowstring sign.
* Simulation:
  + Log Roll Maneuver: An examinee claims to have lower back pain with all movements of the lumbar spine on direct testing and who also complains of lower back pain when the leg is internally and externally rotated at the hip. This is typically done with the examinee in the supine position. The examiner places one hand on the examinee’s thigh and the other hand on the examinee’s calf. Rolling the whole leg at once, the examiner first internally rotates and then externally rotates the entire leg. This causes movement in the hip socket joint only and does not involve the lumbar spine. A report of lower back pain or body language to that effect would be a non-physiologic finding.
  + Hip Wiggle: With the examinee in the supine position, the examiner flexes the hip and the knee both to 90 degrees. It is important to simultaneously flex at both joints to prevent the development of sciatic nerve tension. At the 90:90 positions, the examiner then internally and externally rotates the hip joint. This may produce pain in the presence of hip joint pathology but should not be a source of lower back pain. A report of lower back pain or body language to that effect would be a non-physiologic finding.
  + Toe-Ankle Test: After performing sciatic nerve tension signs such as the straight leg raise maneuver and Braggard’s maneuver, the examiner flexes the supine examinee’s hip and knee and places the examinee’s foot on the examining table. With one hand on the examinee’s elevated knee and the other hand beneath the examinee’s foot and toes, the examiner strongly dorsiflexes the toes and ankle of the foot – similar to the dorsiflexion of the Braggard’s maneuver. This should not produce sciatic nerve tension because of the flexed positions of both the hip and the knee. A report of lower back or radiating leg pain would be a non-physiologic finding.
* Insincerity of Effort: One of the methods that examinee’s may employ to overstate their disability is by exaggerating their loss of physical ability. This may be detected on Symptoms and Activities of Daily Living Questionnaires and also in the Physical Examination. Examples of insincere effort, or inconsistency of effort on Physical Examination maneuvers could include:
  + An examinee demonstrates weakness on resisted knee extension testing (L4 nerve root testing) and yet is observed to be able to rise from a sitting to a standing position without the use of his hands (negative Minor’s sign).
  + An examinee demonstrates great difficulty in rising from sitting to standing (positive Minor’s sign) and yet is observed to be able to perform the repetitive squat maneuver.
  + An examinee demonstrates weakness on resisted ankle dorsiflexion (L5 nerve root) and ankle plantar flexion (S1 nerve root) yet is observed to be able to heel and toe walk without difficulty.

# Waddell’s Signs

The Waddell examination maneuvers were never intended to be used as a stand alone test of malingering. Positive Waddell’s Signs are not definitive for secondary gain and cannot discriminate between organic and non-organic causes of lower back pain. However, the presence of positive Waddell’s Signs are associated with poor treatment outcomes.

* + A supine examinee reports inability to raise his supported left leg out of the examiner’s hand (Millgram’s maneuver) due to report of lower back pain or leg weakness. A sincere attempt at this maneuver involves stabilizing downward *counter pressure* applied by the opposite leg to the examiner’s other hand and this can be felt by the examiner. This is known as a positive Hoover’s sign. In the absence of stabilizing counter pressure by the contralateral (non-test) leg, there is a suspicion of insincere effort.

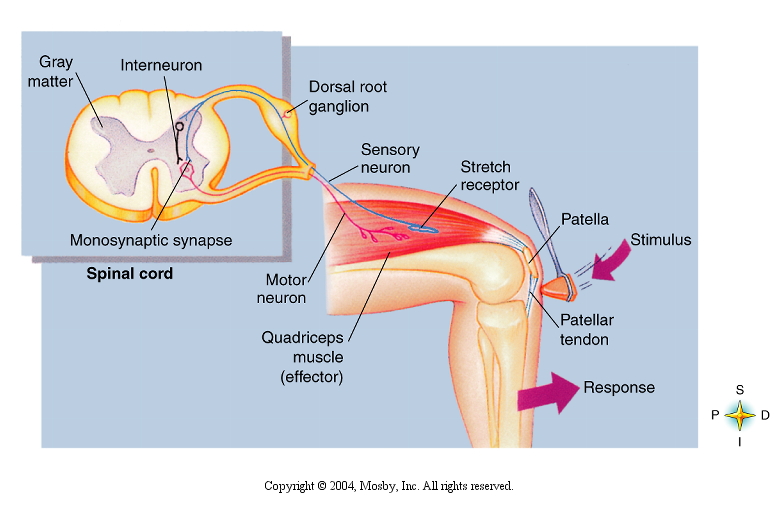
This is by no means an exhaustive listing and you may have your own examples and experience with inconsistent examination findings. With regard to Physical Examination maneuvers, even those outlined above are in large part subject to the examinee’s conscious control and therefore, can be influenced by factors outside of the reported pain syndrome. The only truly Objective Physical Examination procedures that we have are the 1) deep tendon reflexes and 2) measurement for atrophy. Atrophy measurements cannot be influenced by examinee factors and in the presence of true pathology – such as an L4 nerve root lesion causing weakness of the quadriceps muscle, or chronic leg pain following a total hip replacement – there will be atrophy due to pain, disuse, favoritism, or denervation and this can be measured with a tape measure. In addition to reflex testing and measurements for atrophy, it is my opinion that gait analysis also represents a true Objective Physical Examination maneuver. This requires a little explanation because, of course, gait disturbances can be fabricated and/or exaggerated and this requires additional investigation to determine the cause. However, in the presence of a *normal gait* – what can we conclude? Please refer to [www.EZCONTINUINGEDUCATION.ORG](http://www.EZQMECEU.com) for additional discussion of gait in the Article “Gait Disturbance and Assistive Devices.” If you meet your examinee in the waiting room and 1) they follow your command to come back to the examination room, 2) they rise normally from the waiting room chair and walk unassisted and with undisturbed gait, you can conclude that:

1. Sensory systems are intact
2. Motor systems are intact
3. Sensorium is intact
4. Therefore, the entire nervous system is intact. The Physical Examination should be consistent with such findings.

What about deep tendon reflexes? We all perform deep tendon reflexes – both in the upper and lower extremities and it is easy to get routine with testing reflexes and to forget what it is that we are actually testing when we tap the patellar or the triceps tendons. A review of reflex arcs is beyond the scope of this article but the interested reader is referred to [I’ll](http://www.EZQMECEU.com) I’ll ch

and our 6 hour Home Study (Audio) Course entitled “The Importance of the Neurologic Examination” for a detailed discussion of important clinical neurology – including reflex arcs - involved with the QME examination. As an expedited review here, see diagram below for a review of the L4 – patellar reflex arc:

What structures must be functioning normally in the presence of brisk knee and ankle reflexes?



Using the patellar and Achilles reflexes as examples, normal and brisk reflexes at the knee and ankles indicates preserved and intact function of:

* Left and right quadriceps muscle spindles (stretch receptors)
* Left and right gastrocnemius muscle spindles (stretch receptors)
* Left and right L4 sensory nerve roots
* Left and right femoral (L2, L3, and L4 nerve roots) nerves - sensory function
* Left and right S1 sensory nerve roots
* Left and right tibial (L4, L5, S1, S2, and S3 nerve roots) nerves - sensory function
* L4 level of spinal cord
* S1 level of spinal cord
* Left and right L4 motor nerve roots
* Left and right femoral (L2, L3, and L4 nerve roots) nerves - motor function
* Left and right S1 motor nerve roots
* Left and right tibial (L4, L5, S1, S2, and S3 nerve roots) nerves - motor function
* Left and right quadriceps muscles
* Left and right gastrocnemius muscles

That’s a lot of stuff! Thus, in the presence of normal knee and ankle reflexes, many structures must be functioning properly and the History and the Physical Examination should be consistent with such Objective findings.

CONCLUSION

Most examinees that we encounter will be straightforward and honest regarding their industrial injury and their subsequent health conditions. However, because injured workers find themselves – willingly or unwillingly – in the medical legal context (one of the 4 criteria described under the DSM-IV definition of “malingering”), of the Worker’s Compensation system, the examiner must be alert to the possibility of the presence of symptom magnification and/or malingering. As Qualified Medical Evaluators, our job to all parties is to accurately and fairly render conclusions regarding injured workers’ health and, in the event of permanent loss, or loss of use of a part of the body, to render an accurate Permanent Impairment rating that is a *true* description of the resulting loss of function. The above considerations will assist the Qualified Medical Evaluator to sharpen their attention to true Objective Findings associated with documentable pathology.

*References:*

1. *2001 Physician’s Guide – “Factors of Disability” – pages 42-44*
2. *AMA Guides 5th Edition – Common Activities of Daily Living – page 4*
3. *Diagnostic and Statistical Manual of Mental Disorders IV – page 739*
4. *AMA Guides 5th Edition – Common Scales to assess Symptoms and Activities of Daily Living – pages 578-579*
5. *AMA Guides 5th Edition – Observable Pain Behaviors – page 580*
6. *Waddell M.D. – Non-organic Physical Signs in Low Back Pain (1980)*