
NEWTON MEDICAL GROUP

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a multi-disciplinary medical practice specializing in occupational illness and injury, disability evaluation and forensic medicine

HAVE YOU HUGGED YOUR AME TODAY?

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On 5/6/06, WCC published an article written by York McGavin, titled “A Guaranteed Path to Success—When Not to Use an AME”. The author’s thesis was that the AME resolves disputes by “splitting the baby down the middle”. This results in PD somewhat less than that found by the PTP, presumably pleasing the Defense, while finding enough apportionment to appease the defense, but not enough to offend the Applicant. Mr. McGavin characterized this approach as a purposeful design for continued AME referrals from both parties, superior to and in spite of the “detriment” imposed upon injured worker.

Mr. McGavin goes on to recommend an alternative strategy, whereby “the unrepresented IW should trigger the PQME process prior to obtaining representation and insist the AA not agree to have future disputes resolved through an AME.” He concludes that by insisting the AA will only return to this PQME to resolve any future disputes, the result will be a guaranteed path to success for the IW with the best possible outcome in regards to PD, apportionment or future UR disputes.

I read Mr. McGavin’s article first with some curiosity, but on reflection with sadness and regret that turned into a growing sense of outrage. The article not only does a grave disservice to those clinicians who have labored long and hard to become recognized as AMEs, but more importantly discounts the value and importance to all parties—IW and Insurance Carrier alike, to have the claim handled expeditiously and fairly in the wake of a thorough, informed and neutral AME report.

I have performed workers’ compensation evaluations for the last 28 years, starting my career as a QME (though not formerly named such in those times). Early on in my career, I had the opportunity to seek guidance and wisdom about the med-legal process with Dr. Joseph Bernstein who, in Northern California, was regarded as one of the crème de la crème, if not the preeminent AME. Dr. Bernstein asked me “Do you want to be an applicant doctor or a defense doctor?” Not knowing that it was a trick question, I responded that I did not think I wanted to be either, I simply wanted to be a good doctor whose opinions would merit respect if not admiration. Dr. Bernstein’s smile indicated that my reply was the correct answer, and he warned me that that if I aimed to be an AME rather than report for one side or the other, that my career would be slower in the beginning but likely one that would lead to great professional satisfaction doing respected AME med-legal reports in the long run. How right he was!

Through diligence in my clinical specialty and a purposefully crafted reporting ethic, I am now in such a position in the Northern California community to have performed thousands of AME evaluations myself. Further, in my role as Founder of Newton Medical Group, a multidisciplinary medical evaluation practice, I

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have overseen a process whereby more than 20,000 AME have been produced over the years. Never once in that process have I witnessed, let alone considered, utilization of the reprehensible intellectual approach Mr. McGavin imparts to AMEs. Perhaps Mr. McGavin's characterizations merely reflect the triumph of global cynicism, but tarring the AME evaluation with such a broad and poisoned brush is simply too much to let pass.

I have taught on countless and varied industry panels for decades now, speaking before ICAs, the California Defense Attorneys' Association, CAAA, California Self Insureds, WCAB judges groups and CSIMS, as well as coordinating courses through Newton Medical Group as a licensed State of California QME Continuing Education Provider. Attendees of those many meetings will recall that I have railed against the "splitting the baby" model supposedly common to AME exams. In fact, one of my slides is entitled "Splitting the Baby-**NOT**".

The role of the AME is to deliver unbiased reports, letting the medical facts govern the outcome, without regard to securing the next referral. A joke I have long made in my classes is to define an AME as "a clinician who has the rare ability to alienate two referral sources with a single report". At Newton Medical Group, I have established an "AME Mentor Program" to train and develop new AMEs to meet the increasing demands of the community, and the first order of business is to admonish the clinicians to ignore the letterhead of the referral, and to write *each* report as though it was an AME. It is through this type of reporting that credibility is born, not from finding the mathematical middle ground.

As to the clinical and reporting dynamics of "splitting the baby" there are so many instances where this is not even theoretically possible, that the concept bears little merit in either an academic or practical consideration of the AME report. Consider first that in this era of legislated "reform", the AME is no longer the "third" expert, preceded by QMEs on either side whose opinions have spawned a baby to be split. Rather, the AME is now the first and, theoretically at least, the last and presiding expert, without an infant to bifurcate!

A long list of "what abouts" parade forth: What about the AME on treatment issues, or even more specifically on yes/no issues such as surgery. Again, where's the baby? What about AME cases that involve the threshold question of injury AOE/COE? No baby to be seen or heard. Or, how about the "typical" AME evaluation I now see that involves at least two to three injuries, multiple body parts and multiple carriers. How is the "splitting" to be accomplished then? For Mr. McGavin's theory to be practical in such complex circumstances, one would need to possess not only the Wisdom of Solomon but also the mathematical genius of Stephen Hawking to split the multitude of babies being offered.

Turning now to the proposition that the injured worker (IW) is less well served by an AME than by an alternate "strategy", this theory seems built upon a crumbling foundation of assumptions, each of which is open to serious question:

Mr. McGavin tells us the injured worker is to rely upon the advice of his/her treating physician and/or an "astute" Information and Assistance Officer (IAO). Inasmuch as most treating doctors have never sat for the QME examination and are often loath to gain knowledge of the workers' compensation system, it seems a less than optimal choice to make that person a lead source of advice.

With no assurance that the treating doctor has an understanding of the writing skills of the prospective panel submitted to the IW (or even the identity of all the PQMEs), and likewise no assurance that the IAO has an in

depth knowledge of either the panel doctors or, perhaps more importantly, the intricacies legally and medically of a particular IW, this path is one which an experienced attorney should be cautious to specifically recommend.

With regard to regulatory deadlines imposed upon the selection process, I seriously doubt that busy PTPs could schedule a timely follow-up appointment to provide the accurate “advice” on “Dr. Washout” and “Dr. Friendly”, even if they possessed such expansive awareness of the clinicians on the potential panel.

In the age of increased complexity post SB899 – ACOEM, AMA, Escobedo, dual rating – it is reasonable to consider whether the average quality of a panel QME report is the same as that of a recognized AME. Why are non-AME doctors relegated to the panel pool? The individual doctor may be new to the workers’ compensation system, or may simply not perform enough evaluations to have established a name in the community. In either case, what does that tell us? From an experience perspective, while this level of panel QME is no doubt well intended, he/she lacks experience and likely cannot handle extremely complex cases absent the necessity for supplemental report clarification or depositions. Does this not defeat the desire for prompt resolution of a case? Does an AA really want to categorically advise the IW to rely upon the proverbial pig-in-a-poke via the PQME process?

More ominously, doctors may be performing primarily PQMEs precisely because they have the reputation as “Dr. Friendly” or Dr. Wipeout” that Mr. McGavin referenced. While, depending on the referring party, either Dr. Friendly or Dr. Washout may on the surface seem a good choice, it is highly likely that these less experienced clinicians do not carry the greatest degree of credibility with local WCABs. Accordingly, they do not reflect a true “threat” to the opposing party because a skilled attorney can depose the doctor and handily expose flaws in reasoning in any number of ways. Regardless of which party prevails, the timeline has likely been extended greatly.

Incidentally, if there is a supposed incentive for an established and habitually busy AME to “split” cases, how much greater must that incentive be on panel QMEs seeking to make the progression to AME and steady appointments? If the doctor is not seeking to make a progression to AME, then that doctor has likely adopted a position of dogma. In other words, rather than viewing each case individually and coming to legitimate conclusions, a conscious or unconscious drive results in consistently skewed opinions, either pro defense or pro applicant. Either way, whether driven by dogma or accepting Mr. McGavin’s implicit imposition of ill motive, the problem remains.

Among my lectures to various groups is one entitled “The Road to AME.” The metaphor the path implies is a journey (process) where the steps are measured in accrued knowledge, and the journey is never intended to end. The clinician need not and should not sell his intellectual soul to become an AME. I have found over the years that the workers’ compensation system has consistently rewarded clinicians who ignore the agendas of their own referrals. Doing so can trouble, irritate and even anger people on both sides of the equation. Most, however, eventually realize that if they have an accurate read of their case, the knowledgeable AME is the clinician most likely to provide an honest report that allows for the fastest and least painful dispute resolution. I am reminded of the words of Theodore Roosevelt, who, late in his life and presumably drawing from his own accrued experience and wisdom, said, “Justice consists not in being neutral between right and wrong, but in finding out the right and upholding it, wherever found, against the wrong.” No less the charge of the AME.

Lastly, for purposes of historical accuracy, and as readers of the Bible well know, it was the threat, not the act, of splitting the baby that was the genius of Solomon's decision. The true mother surrendered her claim lest her child be slaughtered, and thus Solomon came to a clear and accurate decision. An expression that once referred to an outrageous, unthinkable act has come to be accepted as meaning a reasonable way of being fair to both parties. While that paradigm may well serve public policy, medical opinion in the context of a legal dispute is an altogether different situation. I say, "Long live the baby, and long live the AME who doesn't try to split one".