Quality of evaluation of work disability

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Chapter 6: Interview protocols in social insurance medicine

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Abstract

Background
The quality of the disability evaluation interview – the standard tool for assessing claims in the Netherlands under the Invalidity Insurance Act (WAO) – leaves much to be desired. Pressure to produce a validated and reliable evaluation will be all the more urgent if the plans of the present government are implemented. In the past, attempts have been made to design a valid instrument in the form of interview protocols.

Methods
This article identifies the existing protocols and examines their underlying principles; it also considers their similarities and differences. The three protocols considered are the Disability Assessment Structured Interview (DASI), the Interview of Methodical Assessment (IMA) and the Multi-Causal Analysis (MCA). The similarities and differences of the three protocols were examined in terms of their underlying principles and practical technique.

Results
All were found to be based on the experience of the interviewers and none were appropriately validated. All three are based on a complex of legal, medical and psychological considerations. The similarities between the protocols were found to be greater than the differences. In this article, the principles used to design the protocols are discussed in relation to the research literature. They are underpinned primarily with indirect arguments. Further development and practice-based research could significantly raise the degree of professionalism in this field.


# Introduction

The evaluations performed by insurance physicians are often the subject of criticism [1]. Yet as far as we are aware, the nature of the problem has never been researched: it may be due to faulty procedures, or to evaluations being unreasonably severe or – conversely – much too lenient. Several studies have plausibly argued that evaluations lack consensus [2,3,4,5]. In general, an evaluation is based on pre-information, an interview, a physical examination and sometimes further tests or examinations. In everyday practice, the medical aspect of WAO disability evaluation depends heavily on the interview with the claimant [6,7,8]. It is striking that there is so little scientific underpinning for this aspect of the evaluation.

It seems probable that in the future, the evaluation interview will come under greater pressure in relation to claims under the Work and Income according to Labour Capacity Act (WIA) [9]. Although reintegration reports (including information from specialists) will play a more major role in evaluation than is currently the case, the question about the completeness and permanence of the disability will still be met chiefly by information obtained in the interview [10]. So there is an urgent need for a robust examination instrument in the form of a validated interview protocol of proven effectiveness. However, no such instrument is available to date.

Attempts have been made to design interview protocols for WAO purposes [11,12,13,14,15]. By ‘interview protocols’ we mean schematic rules for conducting interviews, which in essence prescribe the topics to be covered and also the interviewing technique to be employed. The interview protocols currently used in WAO settings are not based on scientific theory. Equally, little research has been carried out into their effectiveness, validity or reliability. Spanjer [17,18] investigated the reproducibility of WAO evaluations, and their inter-rater and intra-rater reliability. He found that evaluations based on a video-presentation of the Disability Assessment Structured Interview were highly reliable in a laboratory setting, but probably less so in practice. In his opinion, physicians did not probe sufficiently with their questions, and paid too much attention to medical matters and disease. The interview protocols are an integral part of the evaluations. Their status is indicated in the recommendations on insurance medicine by the Health Research Council of the Netherlands (RGO) [8]: they are information-gathering models linked to verification models. Two instances of the latter are described in the RGO’s recommendations: the argument-based claim evaluation and the insurance medicine reference framework. We found no evidence of interview protocols based on the insurance medicine reference framework. Nor did we find evidence, either in the literature (PubMed) or via our own research sources, of argument-based protocols being used outside the Netherlands for disability claim evaluation [19].
In this article we consider the following research questions:
What are the similarities and differences between the published protocols?
What are the protocols based on?

Method
By studying descriptions of the published protocols and interviewing their designers, we extrapolated the characteristics, basic principles and claims of the various protocols and set them out in a way which enabled comparison (research question 1.) These interviews were conducted in several rounds. First, we and all the designers jointly drew up a set of concepts, which were subsequently elaborated in bilateral interviews. Afterwards, the results were jointly discussed and checked. This method of working was necessary because the designers each had their own terminology. In practice, there was occasionally a greater degree of consensus than reflected in the written descriptions.

Having found similarities and differences between the various underlying principles, we attempted to identify the basis of each (research question 2). For each basic principle, we examined the literature (Tijdschrift voor Bedrijfs- en Verzekeringsgeneeskunde, PubMed and Psychinfo), looking for theories and protocols which might serve to develop and test the three interview protocols.

Results of research question 1: What protocols are in use?
The first interview protocol to be introduced into insurance medicine and into the training curriculum for insurance physicians was the Interview of Methodical Assessment (IMA) [11,13]. A second type is the Disability Assessment Structured Interview (DASI) [14], which was developed in response to the IMA: the latter was seen as inflexible and insufficiently focused on the Functional Capacity List (FCL). The third type is the Multi-Causal Analysis (MCA) [12,15], which was also designed in response to the IMA’s perceived lack of flexibility and in order to deal with the perceived difficulty of claimants to verbalize their claim effectively at the beginning of the interview. To sum up:
In insurance medicine, there are three published protocols for disability evaluation interviews.
All three protocols are based on legal, medical and psychological considerations.
Parts of the protocols are different, but there are also considerable similarities.

Table 1 presents a systematic comparison of the main features of the protocols. For further details, the reader is referred to the original publications cited.
### Table 1  Comparison of interview protocols in insurance medicine

<table>
<thead>
<tr>
<th>Typical characteristics</th>
<th>Disability Assessment Structured Interview (DASI)</th>
<th>Interview of Methodical Assessment (IMA)</th>
<th>Multi-Causal Analysis (MCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Typical characteristics</strong></td>
<td>Probe for factual, detailed examples of restrictions/limitations &amp; capabilities</td>
<td>Frequent use of summaries</td>
<td>Empathize with claimant; claimant must feel heard (good communication essential!)</td>
</tr>
<tr>
<td><strong>Topics</strong></td>
<td></td>
<td>Address all 9 topics. Same sequence at start of each item (work, claim and claim-related ailments, alternative work)</td>
<td>All 6 topics must be addressed but sequence is free and switching is allowed between topics</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td>Explain purpose of interview</td>
<td>Agree on procedure (first give opinion on present situation and then go on to other issues)</td>
<td>Briefly explain procedure</td>
</tr>
<tr>
<td><strong>Most important feature</strong></td>
<td>All topics must be addressed</td>
<td>All topics must be addressed, using at least 1 leading question</td>
<td>All topics must be addressed</td>
</tr>
<tr>
<td><strong>Ending</strong></td>
<td>Ask if claimant has anything to add</td>
<td>Ask if claimant has anything to add</td>
<td>Refer back to claimant’s restrictions &amp; limitations</td>
</tr>
<tr>
<td></td>
<td>Physician’s conclusion and possible consequences</td>
<td>Final summary Conclusion Follow-up appointments, if any</td>
<td>Offer claimant chance to add anything; pick up on new remarks or unfinished business</td>
</tr>
<tr>
<td></td>
<td>Explain further procedures</td>
<td></td>
<td>Agreements and future planning</td>
</tr>
</tbody>
</table>

**Topics**

- **Work**
- **Disease data**
- **Limitations & restrictions experienced**
- **Activities/ handicaps**
- **Claimant’s opinion (suited to current work or lighter work?)**
- **Physical examination**
- **Physician’s opinion**

**Claim items**

- **w**ork
- **claim & claim-related ailments**
- **alternative work**
- **Verification items**
- **-motivation**
- **-convictions about cause of disease and handicap**
- **-fitness & vitality**
- **-change, mental/personal**
- **-life events**
- **-future**
- **-physical examination**

**Introduction**

- Explain purpose of interview
- Explain procedure
- Summarize case
- Remove any resistance

**Briefly explain procedure**

- **Health**
- **Work**
- **Private life**
- **Functioning**
- **Person**
- **Physical examination** (Claimant’s opinion emerges in all these topics)
Interview protocols

<table>
<thead>
<tr>
<th>Structure</th>
<th>Tight structure, especially in section on 'limitations and restrictions'</th>
<th>Tight structure for first three claim items</th>
<th>Loose structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>30-45 minutes</td>
<td>45 minutes</td>
<td>30-45 minutes</td>
</tr>
<tr>
<td>Verification (consistency &amp; plausibility of argument-based claim evaluation)</td>
<td>Elicit factual, detailed examples (NB consistency) Consistency between all interview topics; also between claimant’s self-report and other information Common sense Insurance physician must be convinced</td>
<td>Achieved through protocol’s structure and probing questions by insurance physician</td>
<td>Gather information by asking and probing on all topics Consistency in claimant’s self-report Supplementary information may be obtained from third parties</td>
</tr>
<tr>
<td>Use of topic summaries as ...</td>
<td>interviewing technique fixed part, concluding each topic (essential to protocol)</td>
<td>interviewing technique</td>
<td></td>
</tr>
<tr>
<td>Sequence of topics</td>
<td>Preferably as prescribed in model, but still at physician’s discretion</td>
<td>Preferably as prescribed in model, but still at physician’s discretion</td>
<td>Free, providing all topics are addressed. Switching allowed between topics.</td>
</tr>
</tbody>
</table>

**Notes:**
Highly typical characteristics are indicated in bold italics. Interpretations and interview styles may vary from one physician to another.

* Verification items: these items may be used by the insurance physician to verify the reliability and consistency of the claimant’s story.
** Normal day: description of a normal day (e.g. the day before the day of the evaluation interview) in the life of the claimant.
*** Spontaneous remarks: claimant’s remarks that are not directly related to the topic currently under discussion.
**** Inadequate answers: claimant’s responses that do not directly relate to the question asked but deviate from it.

**Interview of Methodical Assessment (IMA)**
The IMA’s main underlying principle is the argument-based claim evaluation [8]: the premise is that the claimant’s claim and arguments must be verified and underpinned, with the emphasis on his activity limitations and capacities. The responsibility for underpinning the claim, for incapacity for work and for behaviour towards recuperation rests primarily with the claimant. For this reason, every effort is made in the interview to put the claimant on an equal footing with the insurance physician, and the claimant is tested to see if he is able and willing to bear the responsibility. The interview is semi-structured, with comprehensiveness as its key characteristic. The conversation proceeds according to rules, with a set sequence of questions and a set role for the claimant. Any deviations, such as spontaneous remarks by the claimant, are considered as a result of the test. There are 12 topics to be addressed.
The description of the method contains many detailed instructions on how to ask specific questions and how to interpret answers. Every topic is concluded with a summary. Together, the summaries serve as building-bricks for the overall conclusion. The verification criteria are plausibility, internal consistency, and congruity with insights from medicine and the social sciences. The insurance physician delivers an overall conclusion, underpinning arguments, and an evaluation. The objective is to arrive at a systematic evaluation based as far as possible on verifiable facts.

**Disability Assessment Structured Interview (DASI)**

Here too, the main underlying principle is argument-based claim evaluation [8]. There is a major focus on the differences between the claimant’s current state and pre-morbid state as operationalizations of disease or impairment. Another key role is played by factual and detailed examples that the claimant gives (preferably without prompting) of every activity he performs and of the restriction of capacity that he claims to experience. These examples serve to reduce possible malingering or aggravation by the claimant and to identify residual capacity for work. The interview is semi-structured: the topics are fixed by the insurance physician but they may be addressed in any sequence. Once all the information has been gathered, the insurance physician forms a judgment, which he then clearly states to the claimant. The purpose of this method is to reach a systematic evaluation, focusing on what actually needs to be assessed in practice.

**Multi-Causal Analysis (MCA)**

This interview protocol, too, follows the principle of argument-based claim evaluation [8]. However, in the MCA, the emphasis is on mapping impairment and motivation factors in the claimant. The protocol therefore includes questions about psychological and social aspects, as well as medical. A relationship of trust is vital between the insurance physician and the claimant. The insurance physician should display an attitude of empathy, respect and interest; he should probe where necessary and take due account of the claimant’s subjective perceptions.

The MCA is a heuristic approach which gives considerable freedom to the insurance physician. The topics are fixed but are set out in broad categories. The interview is loosely structured: it may be dynamic, switching from one topic to another on spontaneous cues from the claimant. Probing questions reveal the plausibility and consistency of the claimant’s report and the degree of his incapacity. Any aspect of the claim may be discussed at any point in the interview. The main focus is on the claimant’s perception, so it is essential for the interviewer to keep probing. The purpose of this method is to reach an understanding evaluation.

In practice, the three protocols may not be strictly applied. We know from the literature that assessing physicians tend to be pragmatic in using the
available instruments [3,20]. However, that is a subject beyond the scope of this article.

**Similarities between the protocols**

All three protocols build on the principle of argument-based claim evaluation.
All three protocols seek to identify functional capacities as well as activity limitations.
The truth criteria are: plausibility (is the information submitted in the claim likely to be based in fact?) and consistency (not contradicted in any way by the claimant, and congruent with insights from medicine and the social sciences).
In all three protocols, the evaluation is medical, but it also takes non-medical aspects into account and is therefore multifactorial.
All three protocols are semi-structured, to a greater or lesser degree.

**Differences between the protocols**
The interview has a different character in each protocol: the IMA is like a test, the MCA approximates to a dialogue and the DASI resembles a questionnaire.
Spontaneous remarks and inadequate answers are handled differently: in the IMA and MCA the physician asks more probing questions, whereas in the DASI, he steers the conversation back to the semi-structure by using summaries.
Empowerment is another point of difference, i.e. the physician builds a relationship of trust with the claimant so that the interview becomes a joint activity, enabling the claimant to play an active part in the evaluation and come up with solutions to his health problems. The IMA and MCA seek to empower the claimant, whereas the DASI does not.

The IMA seeks to build up a thorough and detailed picture before a judgment is formed. In the DASI, the assessor’s aim is to identify impairments and capacities, which takes up relatively less time than in the IMA. The MCA is somewhere between the other two protocols on this point.
The aims differ: in the DASI, the aim is to fill in the Functional Capacity List (FCL); other protocols also aim to help the claimant to gain self-understanding, promote his functional restoration and encourage him to get back to work.

The similarities between the protocols appear to be based on certain underlying principles, which form the basis for the second research question.
Results of research question 2: What are the protocols based on?
The similarities and differences between the three protocols derive from their designers’ views about legislation and science. These views are not made explicit in the development and description of the protocols, nor are they underpinned by scientific argument. The descriptions are strongly based on practical experience. All the interview protocols share common underlying principles and the differences between them are mainly a matter of degree. However, none of the protocols has ever been actually validated. On the basis of legislation and scientific knowledge, the following points may be made about the acceptability of the principles themselves:

The designers all start from the principle of the argument-based claim evaluation, i.e. assessing a claim on the basis of arguments submitted by a claimant. This fits in with the statement in the RGO’s recommendation that this is the only approach to have generated instruments for evaluation of work disability [8].

All three protocols link in with the modern notion that an evaluation should be based primarily on positive capacities, besides negative impairments. This is also mandatory for the working method of the Employee Insurance Schemes Implementing Body (UWV), which uses the Functional Capacity List.

The truth criteria (plausibility and consistency) are in line with the Evaluation Decree [21], and before it, the Guidelines on Medical Incapacity for Work (MAOC) [22].

All three protocols represent a multifactorial approach, as opposed to a purely mon causal (medical) one. This explains the variety of topics addressed in the various protocols. All the topics are relevant as pointers towards the claimant’s functioning [21, 23], but the extent of the topic categories and the various options they contain have not yet been subjected to testing. For instance, what is covered by the topic ‘Motivation’ in the IMA? To what extent does it overlap with ‘Impairments experienced’ in the DASI or ‘Person’ in the MCA? There is a substantial overlap in all the protocols as regards the topics to be addressed. Of the three, the IMA is the most detailed and the MCA is least specific.

All three protocols devote attention to the position of the claimant during the interview. The claimant must substantiate his claim (explain why he is no longer working, or only partly working) and collaborate on the evaluation. The assessor must verify whether the information submitted by the claimant in support of the claim is correct, and whether it should be amended or supplemented. It is generally accepted that these positions have an impact on the obtaining of information and the forming of a judgment. For instance, the claimant’s report may understate or exaggerate his ailments, impairments or capacities – in good or bad faith [24]. The exact nature of the impact on the information-gathering process has not yet been established through empirical research: Misleading behaviour due to illness may be common, or it may be rare [25]. Moreover, if somebody
says he cannot work, what is the reason behind this? Is he afraid that working will damage his health? Does he think it unreasonable that he is expected to work in his current circumstances? Or is it simply that he does not want to work? The three protocols all refer to these positional features, for instance in the scripting of the assessor-ASSESSEE relationship in the introduction, the list of topics to be addressed and the manner in which they are to be addressed.

According to the protocols, the relationship between the claimant and the insurance physician is to be managed by specific techniques. This depends, among other things, on how each one views his task and role in the interview. Is it based on a classical doctor-patient relationship (especially in the MCA) or is the claimant supposed to be a talkative individual with aims of his own (especially in the MCA), who resolves a problem with a doctor [26]? The latter is preferable when the aims of the assessor and the claimant are the same. This is least stressed with the DASI: the greater the difference of opinion between the two about the outcome of the evaluation, the more likely that the evaluation will turn into a conflict of interest that will have to be handled through conflict behaviour.

The key role part played by conflict resolution is also reflected in the emphasis given to this topic in the training, education and protocols that pertain to this professional field. In the literature, the relational component is offered as a possible explanation for the differences between assessors [7,8,9]. For instance, poor interaction with the claimant may incline the assessor to think that the claimant’s symptoms or impairments are difficult to objectify. The three protocols display no significant differences on this point.

All the interviews can be interpreted as ways of testing what the claimant sees as his capacities. From a legal point of view, this is a sound argument, since anybody who makes a claim must be able to substantiate it. Another argument is that the claimant is the person best acquainted with his own situation. Two recent doctoral dissertations [5,28] have shown that the reliability of self-report is debatable. The value of self-report in incapacity evaluations has not yet been established by empirical research, so for the insurance physician, it is a problematic starting-point. Another argument in favour of verifying the claimant’s self-report is that the claimant will be more inclined to put his capacities to good use if he feels his voice has been heard during the evaluation interview and that he has made a positive contribution to the outcome. This principle is confirmed in the literature on empowerment: the greater the claimant’s participation in decision-making, the more his empowerment increases [29]. It has not yet been established whether this also applies to disability claim evaluation.

All three protocols feature a combination of semi-structuring and, where appropriate, probing. Both are found to a varying degree. Semi-structuring is an obvious option for a number of reasons. Firstly, it is an efficient way of addressing the core of a problem, assuming the assessor is generally familiar with the nature of the problem. Secondly, it prevents the assessor
from falling into his own trap: for instance, his extensive past experience may cause him to jump to a conclusion so that he misses unexpected information or overlooks contradictory details, and then proceeds to form a judgement [30]. Thirdly, semi-structuring is one way of making cases comparable: by always using the same set of questions, one is soon alerted to any discrepancies in the claimant’s self-report. This is the reason why the IMA is a kind of test. The protocols display differences in interpretation of the tasks. It is always debatable how extensive an evaluation should be in order to be described as ‘sufficient’. All three protocols state the aim of being both efficient and comprehensive, each in its own way. However, the descriptions reveal that the IMA is the most detailed, while the DASI is the most strategic. How this works in practice, and on what basis the one might be preferred to the other, is unknown.

Another difference in interpretation of the tasks has to do with whether the assessor should solely focus on evaluating the claim or also aim to help the claimant further. The DASI focuses on the former, whereas the MCA emphatically targets the latter.

Discussion
In comparing the interview protocols that play such a key role in disability evaluation, we find similarities and differences. The fact that the protocols can now be compared and are therefore susceptible to evaluation, may be seen as a step forward. It is striking that such an evaluation has never taken place in the past. It is also noteworthy that the theoretical and empirical basis of the protocols is so implicit. This prompts the view that evaluations are conducted in a ‘black box’ and that the claimant may not have sufficient opportunity to exercise his rights. For the sake of the professional status of insurance medicine, it is desirable that the evaluation interview instrument should be implemented in a transparent and fully validated manner. At present, this is not sufficiently the case. That does not mean that doctors play their interviews by ear: there is no evidence of this from the protocols. For instance, the medical approach and interpretation of the law seem to be sound and defensible in all the protocols. Nevertheless, there is considerable divergence between notions from the behavioural sciences and those from insurance medicine. In practice, the relational aspects of the protocols and the degree of structuring may make a significant difference. Some of the principles, such as the value of certain interviewing techniques in the opinion-forming process, lend themselves to empirical study. The debate about the interpretation of tasks touches on dilemmas that are inherent to the profession, and are best managed through consensus [31,32]. This means that social insurance physicians must continually adapt to the socio-political reality of their day and age [33].
Conclusions

1. There are similarities and differences between the three protocols.
2. None of the protocols is the best of the three; in fact, no single protocol has proven to be sound.
3. The underlying principles - plausibility and consistency as truth criteria, relational fastidiousness, the multifactorial approach and semi-structuring – all of these are acceptable, but they require empirical underpinning for disability evaluation settings under the terms of the Invalidity Insurance Act.
4. Several of the differences between the protocols (such as whether the claimant should not only be assessed but also activated, and whether the evaluation is efficient) raise questions about the valid concerns of insurance medicine, and what these ought to be. However, this is a matter of requiring a consensus within the profession as a whole and in consultation with the UWV.

Recommendations

We think that the interviews based on these protocols can help to make insurance medicine more professional. The three protocols are based on relatively acceptable basic principles. However, it would be desirable to test out those principles in the insurance medicine context so that professional practice is scientifically underpinned. In parallel to this, insurance medicine practitioners could develop general criteria for the evaluation interview, which would not only be a matter of good science but also of creating consensus on the depth, efficiency and standards which are desirable for the profession. Further research into the effects of the differences between the protocols, as well as into their practical use by insurance physicians, is also desirable. It is doubtful whether a single model will ever be rated as ideal, but in the near future, it should certainly be possible to give disability evaluations a sounder and more scientific basis than they have at present.
Chapter 6
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Chapter 6


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