

# Independent Medical Examinations: An Expanding Source of Physician Liability

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Employers frequently ask physicians to conduct medical examinations and review radiology films and other diagnostic tests of employees. Physicians also provide such services at the request of other third parties. These examinations are commonly called *independent medical examinations*. Increasingly, patients are bringing and prevailing in medical malpractice lawsuits against physicians who conduct independent medical examinations, in part because of physicians' misconceptions of their legal duties in this context. Despite the absence of a traditional physician–patient relationship, physicians who conduct independent medical examinations still owe various legal duties to the examinee patient, although the precise scope of those duties is a source of constant

debate and change. Since 2001 alone, 4 state supreme courts have exercised their discretion to hear cases on this issue, bearing witness to its medical, legal, and social significance. Given the current medical malpractice climate, it is imperative that physicians understand the potential liability inherent in conducting independent medical examinations. This article summarizes controlling law, clarifying an otherwise muddled legal picture. It also offers practical suggestions for limiting physician liability in independent medical examinations.

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**B**roadly defined, an independent medical examination (IME) is any health assessment conducted by a physician, not otherwise involved in the care or treatment of the patient, at the request of a third party that is not the physician's general employer. Most commonly, physicians conduct IMEs at the request of employers seeking to determine the health status of their employees, although the circumstances vary. Data are not available on the precise number of IMEs performed each year; however, given the vast number of employers and other interested third parties, it is safe to assume that they number in the tens of thousands, if not more. Yet few physicians appreciate the potential liability they incur as a result of such engagements. Many physicians believe that when they conduct examinations at the request of a hiring third party, as opposed to the patient, there is no physician–patient relationship and, hence, no potential malpractice liability. But as several courts have recently declared, it is not that simple.

In 2004, the Michigan Supreme Court held that a physician who conducts an IME for personal injury litigation creates a limited physician–patient relationship, and therefore may be liable for physical harm caused to the patient during the examination (1). Also in 2004, the Arizona Supreme Court decided that a radiologist interpreting a chest radiograph obtained for tuberculosis screening at the request of an employer may be liable for failing to take reasonable steps to inform the patient of unrelated findings suggestive of a potentially life-threatening condition (2). The highest courts in at least 4 other states—Colorado (3), Connecticut (4), Montana (5), and New Jersey (6)—have addressed the issue of physician liability in IMEs in the past few years, and all have recognized the potential for liability in certain circumstances. Indeed, the question is not whether patients can sue IME physicians; they can and they do. Rather, the question is the scope of that liability.

## A QUESTION OF DUTY

To prevail, patients who sue physicians for medical malpractice must prove by a preponderance of the evidence 4 essential elements: 1) a duty of care owed by the physician to the patient, 2) a breach of that duty, 3) damage to the patient, and 4) a sufficient causal connection between the breach and the damage (7). While any or all of these elements may be disputed in a lawsuit, most cases involving IMEs turn on the first element—whether the physician owes a particular duty of care to the patient.

Whether a physician owes a *legal* duty of care to a patient depends on the existence of a physician–patient relationship. At least in theory, this concept is straightforward: If a physician enters into a professional relationship with a patient, the physician assumes a legal duty to act with reasonable care and skill in his or her professional interactions with the patient. Failure to adhere to this reasonability standard, which itself is defined by the prevailing practices of similarly trained and situated physicians, can leave a physician liable for any resulting damage to the patient. But if no physician–patient relationship exists, the physician owes no legal duty of care to the patient and therefore cannot be liable for any injuries. Consider a physician walking down the street who fails to stop and assist a stranger in medical need. Although ethically suspect, the physician's inaction cannot result in legal liability, even if action would have prevented injury, since no physician–patient relationship and, hence, no duty of care exists.

In practice, however, it is not always easy to determine whether a physician–patient relationship has been formed.

See also:

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**Table. Potential Duties the Independent Medical Examination Physician May Owe to the Patient**

|                                                              |
|--------------------------------------------------------------|
| Duty not to cause physical injury during the examination     |
| Duty to diagnose significant medical conditions accurately   |
| Duty to disclose significant findings in a reasonable manner |
| Duty to maintain confidentiality                             |

What degree of interaction is sufficient to create this relationship and give rise to a legal duty of care? Specifically, does the IME itself trigger this relationship and resultant duty? Does the fact that a third party, and not the patient, requests and pays for the IME make any difference? Courts in almost all states have grappled with these issues. While the decisions are split, the majority rule, and recent trend, is that the IME creates at least a limited physician–patient relationship—not as broad as the typical relationship between a treating physician and patient, yet still sufficient to sustain certain malpractice claims. Of note, the American Medical Association (AMA) concurs, stating in its Code of Medical Ethics, “When a physician is responsible for performing an isolated assessment of an individual’s health or disability for an employer, business, or insurer, a limited patient-physician relationship should be considered to exist” (8).

## A QUESTION OF SCOPE

If the threshold legal finding of duty is made, the inquiry logically turns to the scope of that duty. In law, duties are bounded creatures—they extend only so far. For example, a physician might owe a duty not to cause physical harm during an IME but not owe that same patient a duty to diagnose significant medical conditions accurately. In other words, legal duties can have different scopes in different circumstances. Broadly speaking, IME physicians can take on the following legal duties to their patients: 1) the duty not to cause injury during the examination, 2) the duty to diagnose significant medical conditions accurately, 3) the duty to disclose significant findings in a reasonable manner, and 4) the duty to maintain confidentiality (Table). When contracting with a third party, such as an employer, the IME physician also assumes obligations directly to that party, which may parallel the above duties of diagnosis and disclosure. The following discussion focuses on professional duties to the patient, not contractual obligations to the hiring third party, although the IME physician should recognize both.

### The Duty Not To Cause Injury

The duty not to cause injury is perhaps the least controversial of these duties. It is quite reasonable to expect that a physician will conduct an IME without physically harming the patient in the process. When a physician breaches the standard of care while performing an examination and this breach physically harms the patient, the physician may be held accountable. In the Michigan case

*Dyer v. Trachtman*, the patient, Mr. Dyer, injured his shoulder during a physical altercation with another man and sued that man for the injury. As part of that litigation, the defendant hired a physician, Dr. Trachtman, to conduct an IME to assess the true nature of Mr. Dyer’s injury. After the IME, Mr. Dyer filed a second lawsuit, this time against Dr. Trachtman. According to Mr. Dyer, he informed Dr. Trachtman at the beginning of the IME of his recent shoulder surgery for a torn labrum and that the surgeon had placed range-of-motion restrictions on that arm. Mr. Dyer alleged, however, that Dr. Trachtman disregarded this information and reinjured his labrum while testing range of motion. The Michigan Supreme Court held that Dr. Trachtman could be liable for medical malpractice under these circumstances for *directly* causing physical harm to Mr. Dyer (1).

Of note, the Colorado Supreme Court has held that an IME physician may also be liable for *indirectly* causing physical harm to a patient. In *Greenberg v. Perkins*, the patient, Mrs. Perkins, sustained neck and arm injuries while riding a bus and sued the bus driver and bus owner to recover for those injuries. In the course of that litigation, the defendants hired a physician, Dr. Greenberg, to assess the severity of Mrs. Perkins’ injuries. During the IME, Mrs. Perkins allegedly informed Dr. Greenberg that she had a history of back problems, including multiple back surgeries. On the basis of his examination, Dr. Greenberg suspected that Mrs. Perkins was exaggerating her injuries, so he referred her to a physical therapist for functional testing to confirm his suspicion. The functional testing that Dr. Greenberg ordered was extensive, consisting of 2 hours of lifting and pushing exercises. While completing the tests, Mrs. Perkins reinjured her back and required additional back surgery. She then sued Dr. Greenberg, claiming that it was negligent to refer her for functional testing in light of her preexisting back condition. Even though Dr. Greenberg did not conduct or even supervise the testing, the Colorado Supreme Court held that he could be liable for Mrs. Perkins’ back injury if he failed to exercise reasonable care in ordering the testing (9).

Almost without exception, courts that find a physician–patient relationship arising from an IME interpret the resulting legal duty to encompass the obligation not to harm the patient during the examination. Even courts that do not find a physician–patient relationship frequently uphold claims for physical injury resulting from an IME, relying on principles of ordinary negligence (as opposed to professional negligence or medical malpractice). Of course, physicians who *intentionally* harm or molest patients during IMEs, or any examination for that matter, may face assault, battery, or sexual assault charges.

### The Duty To Diagnose

More controversial is the IME physician’s duty to the patient to diagnose significant medical conditions accurately. Arguments against imposing this duty center on the

limited purpose of the IME compared with the treating physician's examination. Often, third parties hire physicians to conduct narrow IMEs looking for specific conditions only, such as communicable diseases or physical limitations. Indeed, the IME contract frequently states that the physician may not perform additional diagnostic testing without the express prior consent of the hiring third party. As a result, IME physicians usually do not conduct a complete history and physical examination, nor do they generally have access to the patient's entire medical record. Some argue that, under these circumstances, it is unreasonable to hold IME physicians to the same diagnostic standard of care as treating physicians. Other arguments emphasize the potential chilling effect such liability would have on physicians' willingness to conduct IMEs at all.

In contrast, arguments in favor of the duty to diagnose focus on the patient's expectations. When a patient submits to a medical examination, even at the request of a third party, he or she expects that the physician will exercise reasonable care in assessing overall health. Therefore, if the patient has a significant medical condition that a treating physician of similar training and experience would diagnose, then the patient has a reasonable expectation that the IME physician will also diagnose the condition. Conversely, the patient may reasonably equate a lack of diagnosis from the IME physician with a clean bill of health, thereby forgoing a regular check-up. From this perspective, the role of the third party is irrelevant to the patient's expectations.

Again, courts are split, but the majority rule holds that the IME physician does *not* owe a duty to the patient to diagnose any significant medical conditions accurately (although, as noted earlier, the physician may still have a contractual obligation to the hiring third party to diagnose accurately). It is important to note that the case law also suggests that physicians can create or expand this duty to diagnose by affirmatively offering diagnostic or therapeutic advice during the IME—even with the proverbial “Everything is fine” comment—because doing so potentially induces the patient to rely on that advice to the exclusion of routine or follow-up medical care (4).

On occasion, the IME physician may believe that additional diagnostic testing is warranted beyond that authorized in the IME contract. In such circumstances, the most reasonable course of action for the physician is to seek the hiring third party's consent to conduct the additional testing. Should the third party refuse to authorize necessary diagnostic testing for a potentially significant medical condition, the physician is encouraged to recommend that the patient follow up with an existing provider, and to emphasize that the IME and partial diagnostic testing is not an adequate substitute for a complete work-up. If appropriate, the IME physician can offer the patient a letter explaining the concern to assist the existing provider with following up. In addition, the IME physician should thoroughly document the request for additional testing, the refusal of the

hiring third party to authorize the testing, and the resulting discussion with the patient.

### The Duty To Disclose

What if a physician discovers a significant medical condition during an IME? Is the physician legally obligated to disclose those findings directly to the patient? Or is it enough to disclose the findings to the hiring third party, who in turn can notify the patient? Given the lack of a preexisting relationship between the IME physician and the patient—particularly a radiologist reading a screening film of a patient that he or she has never met—it may seem inappropriate to require the physician to bear the burden of disclosure. Imposing this duty is even more dubious if the hiring third party has taken on a contractual obligation to disclose to the patient any significant findings reported by the IME physician.

On the other hand, one can argue that the IME physician is ethically obligated to ensure proper disclosure of significant medical findings to the patient, regardless of third-party contracts. After all, caring for the patient is the core tenet of medical practice, and the IME physician is often in a unique position to prevent foreseeable harm, especially if the alternative to direct disclosure is indirect disclosure by a third party who lacks medical training. And again, the patient arguably has a reasonable expectation that the diagnosing physician—even an IME physician—will warn of any significant medical findings. From a policy perspective, then, the patient is most likely to receive prompt treatment (and avoid slipping through the cracks of a multiparty system) when the physician who diagnoses is also the one who discloses.

As one might expect, the courts differ on this issue, too, but here the majority rule (and recent trend) is that the IME physician has a duty to take reasonable steps to ensure that the patient is advised of significant medical findings. The Arizona radiologist case is instructive. In this case, the IME radiologist reviewed a chest radiograph ordered for tuberculosis screening at the request of an employer and incidentally noted a small lung nodule and patchy consolidation. The radiologist informed the employer of these findings but did not inform the patient directly. The employer never told the patient about these findings—despite a company policy requiring it to do so—and the patient was diagnosed with lung cancer 10 months later. The patient sued the radiologist for delayed diagnosis and treatment that resulted in a less favorable prognosis. The Arizona Supreme Court held that despite disclosing the findings to the employer, the radiologist could still be liable for failing to take sufficient, reasonable steps to inform the patient of the potentially life-threatening findings, should a jury conclude that the prevailing standard of care required greater efforts on the part of the radiologist. In other words, while the Arizona Supreme Court did find that the radiologist owed the patient a duty of reasonable disclosure, it did not decide whether the radiologist

breached that duty. Instead, the Arizona Supreme Court sent the case back for trial (2).

Sadly, the patient died while the appeal was pending before the Arizona Supreme Court. When the case was sent back for trial, the patient's family chose not to pursue the claim, so it was dismissed. As a result, the standard of care issue was never reached. However, given the realities of radiology practice, it is hard to imagine that the patient would have prevailed. In routine medical practice, radiologists rarely contact patients directly to discuss their findings. Instead, radiologists ordinarily communicate findings to the patient's treating physician, and follow-up is usually considered the responsibility of the treating physician, not the radiologist. Presumably, then, it would have been difficult for the patient to establish that the standard of care required the radiologist to communicate the findings directly. Perhaps one could argue that the absence of a referring physician in the IME context sufficiently distinguishes IMEs from routine practice to justify such a drastic alteration in a radiologist's obligations. However, even that argument is questionable where, as here, the hiring third party had taken on the obligation of direct disclosure to the patient. Regardless, radiologists who interpret films in the context of IMEs should be aware that the lack of a traditional physician–patient relationship may not, by itself, preclude the possibility of legal liability for failure to disclose in all circumstances.

The AMA also endorses the duty to disclose, stating that "The [IME] physician has a responsibility to inform the patient about important health information or abnormalities that he or she discovers during the course of the examination" (8). The AMA opinion continues, "In addition, the physician should ensure to the extent possible that the patient understands the problem or diagnosis. Furthermore, when appropriate, the physician should suggest that the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care" (8). Considering the broad wording of this opinion, however, it is not clear whether the AMA intended it to apply to radiologists in addition to physicians who conduct physical examinations.

### The Duty To Maintain Confidentiality

Like all health care providers, IME physicians are bound by state and federal confidentiality laws, most notably the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) (10). As a result, with some exceptions, IME physicians can share medical information with parties other than the patient only if authorized by the patient. Of course, in the IME context, the physician is expected to share certain medical information and findings with the hiring third party. Despite this expectation, the cautious IME physician should discuss this arrangement with the patient to ensure a common understanding of the intended flow of medical information. Interestingly, HIPAA provides that physicians who perform

medical services, such as IMEs, for the purpose of providing information to third parties may require, before performing the services, that patients authorize the disclosure of medical information and findings to the hiring third party (11).

### IMPLICATIONS AND RECOMMENDATIONS FOR IME PHYSICIANS

Overall, patients generally *can* successfully sue IME physicians for negligently causing physical injury during the examination, failing to take reasonable steps to disclose significant medical findings to the patient, and disclosing confidential medical information to third parties without authorization, but they *cannot* successfully sue for inaccurate or missed diagnoses (although this, too, may be changing). What does this mean for the IME physician? Following is a summary of key implications and recommendations for limiting IME liability.

1. Physicians presented with IME engagements should make informed employment decisions. To that end, physicians must recognize that by conducting an IME, they enter into a physician–patient relationship in the eyes of the law, and thereby assume certain legal duties to the patient. Physicians must also understand the scope of the legal duties and liabilities they take on by virtue of the IME (which in some states may include a duty to diagnose), and act accordingly.

2. As with most medical malpractice litigation, the IME physician's best defense is clear communication and thorough documentation. Physicians should explicitly inform patients that they are acting on behalf of a third party and that the IME does not replace regular medical check-ups and care. This discussion will eliminate confusion about the purpose of the IME and safeguard against future claims that the patient reasonably relied on the IME physician for general medical care.

3. To preempt breach of confidentiality claims, physicians should tell patients who, other than the patient, will receive medical information or findings arising from the IME, and obtain the patient's written authorization for such disclosures before conducting the IME, using an authorization form compliant with both HIPAA and applicable state confidentiality laws.

4. Physicians performing an IME should take reasonable steps to disclose significant medical findings to the patient and, when appropriate, recommend follow-up with another physician. This is both the legal and ethical course of action. Whether direct disclosure is warranted will depend on the circumstances. Alternatively, the physician might agree with the patient at the outset that results will be reported to the hiring third party only, who in turn will take responsibility for sharing any significant findings with the patient. Again, any such agreement should be thoroughly documented. Physicians should understand, how-

ever, that even documented agreements may not shield them completely from future malpractice claims.

5. Finally, IME physicians must be aware that by providing affirmative medical treatment or advice, they may expand the scope of their legal duties to the patient, and hence their potential liability.

## CONCLUSION

Independent medical examinations serve valuable individual and social goals, but participating physicians must appreciate the legal exposure they create. Given the realities of our medical malpractice system, physicians' employment decisions, like patients' treatment decisions, should be adequately informed. While this article summarizes current controlling law, the contours of IME physician liability are constantly shifting. Therefore, physicians who conduct IMEs should stay abreast of evolving legal standards, through the assistance of either local and state medical boards or malpractice defense lawyers. In this climate, the prudent physician recognizes that continuing legal education is not for lawyers alone.

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## References

1. Dyer v. Trachtman, 679 N.W.2d 311 (Mich. 2004).
2. Stanley v. McCarver, 92 P.3d 849 (Ariz. 2004).
3. Martinez v. Lewis, 969 P.2d 213 (Colo. 1998).
4. Dugan v. Mobile Medical Testing Services, Inc., 830 A.2d 752 (Conn. 2003).
5. Webb v. T.D., 951 P.2d 1008 (Mont. 1997).
6. Reed v. Bojarski, 764 A.2d 433 (N.J. 2001).
7. See, e.g., Burgess v. Superior Court, 2 Cal. 4th 1064, 1077 (Cal. 1992).
8. Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions, Opinion 10.03, Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations*. 2004-2005 edition. Chicago: American Medical Assoc; 2004:303-4.
9. Greenberg v. Perkins, 845 P.2d 530 (Colo. 1993).
10. Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) and regulations promulgated at 45 CFR Part 164.
11. 45 CFR § 164.508(b)(4)(iii).